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The organization, financing and cost of health care in the European Community

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The organization, financing and cost of health care in the European Community

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C o n t e n t s

Part I

THE ORGANIZATION AND FINANCING OF HEALTH CARE

A. INTRODUCTION

The objective of this section of the report is to analyse the health care systems of each of the nine Member States of the European Community.

Each of the country chapters which follow are divided up in five sections:

- a general description of the evolution of each health care system and an outline of its present administrative structure;
- an analysis of the extent and type of health insurance coverage in each country;
- the financial characteristics of each system;
- a brief summary of the range of benefits which is available and this is presented in the form of a network analysis and a 'typical' patient progressing through the health care system;
- an analysis of the main input series (numbers of hospital beds, numbers of doctors and their remuneration) and an attempt is made to emphasize the difference between stocks and flows and 'equity' of national geographical distributions.

Throughout the analysis great effort has been made to make the coverage of each country chapter uniform.

However in some cases unusual features in particular countries have necessitated a departure from this objective.

B. HEALTH CARE IN BELGIUM

B.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

B.1.1. Evolution

The first national law to affect the finance and provision of health care in Belgium was enacted in 1894. Compulsory social insurance for health care was introduced in 1945 (degree of 28 December, 1944) but was not comprehensive. Legislation in 1963 extended the coverage of the compulsory social insurance programme.

B.1.2. Administrative Structure

The administrative structure of the Belgian health care system is very complex.

B.1.2.1. Government

At the national level there are seven ministries involved in national policy making, guidance and control in the care field - Labour, Public Work, Defence, Agriculture, Education, Public Health and the Family, and Social Welfare. Of these seven ministries, the Ministry of Social Welfare is of primary importance with regard to the general social insurance scheme and scheme for the self employed. The Ministry is concerned with the whole range of social security benefits. Social security contributions to finance these benefits, which includes health care, is paid to an autonomous organ of the ministry (ONSS - the National Social Security Organization) which divides the monies amongst the various benefit programmes. The health care revenues are given to INAMI (the National Sickness Insurance Institution) which divides it amongst the six groupings of sickness funds.

There are 600 local government areas (the smallest unit has 5 000 inhabitants) and these bodies have an important role in the provision of health care (e.g. public hospitals).

B.1.2.2. Sickness funds

There are six groupings of sickness funds. There are five confederations of sickness funds: the National Alliance of Christian Mutual Societies (ANC, 35 federations grouping 752 funds) which covers about 45% of the insured population; the National Union of Belgian Non-Denominational Mutual Societies (UNN, 31 federations grouping 454 funds) which covers about 10% of the insured population; the National Union of Socialist Mutual Societies (UNS, 28 federations grouping 108 funds) which covers 29% of the insured population; the National Union of Belgian Liberal Mutual Societies (UNL, 17 federations grouping 236 funds) which covers about 5% of the insured population; the National Union of Belgian Occupational Mutual Societies (UNP, 13 federations grouping 175 funds) which covers 10% of the insured population; and the Auxiliary Fund (CAAMI) which covers the rest of the compulsorily insured population. The 1 745 sickness funds are the administrative units which reimburse the insured and the institutions which provide care. The employees of the Belgian railway and their dependents and seamen and their dependents have separate insurance arrangements.

Two types of additional insurances are offered by the sickness funds, 'compulsory-voluntary' insurance and voluntary insurance. Compulsory-voluntary insurance is not laid down in statute law but membership of a particular sickness fund obliges the insured person to contribute towards the cost of provision. Voluntary insurance is provided by the funds to 'top up' statutory benefits.

B.1.2.3. Other

The activities of the private insurance market are small.

B.2. COVERAGE

Like France, Belgium does not have one system of social insurance for health care. However the effect of the various statutory schemes is that over 99% of the population have social insurance cover. (In 1960 the extent of coverage was only 73%. However the extent of coverage varies between the various groups. In particular the self employed and their dependents (some 1.5 million) are covered for heavy risks only (hospital care, the social diseases (TB, cancer etc.), etc).

Those not covered, in part or in whole, by the social insurance schemes have access to the social aid programme (means' tested benefits provided by local government).

B.3. FINANCE

The sickness funds have to balance income and expenditure by estimating their future costs and negotiations with INAMI (see section B.1.2.1. above) to acquire an income sufficient to meet its obligations. The funds finance the payment of hospitals and doctors.

B.3.1. Income

B.3.1.1. Contributions by the insured

The contribution rates for health care social insurance are of two types: one for general scheme beneficiaries (who have full cover) and one for heavy risk beneficiaries (i.e. the self-employed who only have partial cover). At 1 June 1978, the contribution rate for general benefits in kind for those in the general scheme, levied on wages, without any ceiling, was 3.75% for employers and 1.80% for employees, a total of 5.55%. The programme for the self-employed is financed by a contribution related to their income.

Railway workers and seamen pay different levels of contribution.

The contribution rates finance medical care only.

B.3.1.2. Government contributions

The State meets 95% of the cost of treating the social diseases (cancer, TB, poliomyelitis, mental illness and handicap). For ordinary medical care a State subsidy of 27% of the budget of the insurance institutions is paid to INAMI. The State pays contributions to sickness funds on behalf of the unemployed (at a rate equal to the average daily value of all contributions for all insurance organizations for each day of unemployment). Also the Government at the local level finances social aid health care benefits.

It is important to note that despite this substantial involvement in the financing of care, the State exercises little control over expenditure. The sickness funds are autonomous and decentralized to a considerable degree.

B.3.1.3. Private finance

B.3.1.3.1. Private insurance

The premium income of private insurance institutions is small.

The income of the social insurance schemes which provide voluntary and 'voluntary-compulsory' (see section B.1.2.2. above) is considerable (see Table 1).

Table 1

(Mio BFR)

	Operating costs	Investments	Total
State expenditure	17 832.8	6 854.7	24 687.5
Social Security	89 008.0		89 008.0
Provinces	2 209.0	369.1	2 578.1
Municipalities	391.0	4 593.7	4 984.7
Semi-Public and private	68 848.6		68 848.6
TOTAL	178 289.4	11 817.5	190 106.9
As percentages			
State expenditure	10.0	58.0	13.0
Social security	49.9		46.8
Provinces	1.2	3.1	1.4
Municipalities	0.2	38.9	2.6
Semi-Public and private	38.7		36.2
TOTAL	100.0	100.0	100.0

B.3.1.3.2. Pricing

The private insurance and the additional insurance provided by the sickness funds and firms enables the insured to meet the costs of care which are not covered by social insurance. The

extent of social insurance reimbursement is determined by the ticket moderateur. Generally patients pay 25% of tariffs for primary care (plus any excess charge over and above these tariffs). If old-age pensioners, orphans, widows and invalids have an income not exceeding BFR 213.438 (pensioners) (1978) plus BFR 41.395 for each dependent they can get a higher level of exemption from the fees (usually 100% of agreed tariffs). A lump sum charge is levied for pharmaceutical products, with exemptions for the pensioner and the other groups cited above. Hospitalization is free with the 25% ticket moderateur being financed by the State.

B.3.1.3.3. Private resources

Private expenditure was about BFR 35.000 million in 1975.

B.3.2. Expenditure

B.3.2.1. GNP

According to official estimates the percentage of Belgian GNP spent on health care before 1973 are not available.[1] In 1973 4.5% of Belgian GNP was spent on health care. By 1974 the percentage was 5.0 and by 1975 6.2 of GNP was being spent on health care in Belgium.

B.3.2.2. Expenditure characteristics

An attempt has been made to aggregate the expenditure series (social insurance. State subsidies, prices, private insurance and private resources). The income side is given in Table 1, and relates to the total costs of health care, curative and preventive.

The expenditure level given in Table 2 is less than the revenue level given in Table 1 because the former table present details only of expenditures on curative health care. The difference (BFR 46 000 million) is spent on preventative care (BFR 29 416 million), industrial medicine (BFR 8 272 million) and the health related activities of the Education ministry.

[1] The figures for compulsory sickness insurance benefits in kind are: 1969: 2.83%, 1970: 2.94%, 1971: 2.98%, 1972: 3.12%, 1973: 3.25%, 1974: 3.32%, 1975: 3.81% of GNP.

Table 2

Expenditure on Health Care by Spending Authority, 1975

(Mio BFR)

	Operating Costs	Investments	Total
Central Government			
Ministry of Public Health	6 556.7	4 400.0	10 956.7
Ministry of Social Security	1 192.0		1 192.0
Ministry of Justice	128.7		128.7
Ministry of Defence	1 814.8		1.814.8
National Institute for Insurance against Sickness and Disablement	89 008.0		89 008.0
Provinces	907.7	109.0	1 016.7
Municipalities	391.0	4 593.7	4 984.7
Private expenditure	35 603.2		35 603.2
GRAND TOTAL	135 602.1	9 102.7	144 704.8

Table 3

General Scheme Expenditure by Category 1976

(Mio BFR)

1. Medical fees	36 066
2. Physiotherapy etc.	5 347
3. Artificial limbs and other appliances	1 143
4. Dentures	2 848
5. Drugs	17 551
6. Hospital costs	18 245
7. Other	1 676
8. Social illnesses	5 960
TOTAL	86 836

Source: INAMI Report for 1976 (1978)

B.3.2.2.1. The expenditure pattern

Table 3 gives some details of the expenditure pattern of the general scheme in 1976 - Medical fees, drug and hospital costs are the major expenditure items.

B.3.2.2.2. The growth of expenditure

The expenditure of the general scheme grew at an annual nominal rate of 18 to 25% in the period 1973-76, from a base of 100 in 1972 to 213 in 1976. During the same period prices rose from 100 to 148. It is clear that the real rate of increase in expenditure by the general scheme was considerable.

B.4. BENEFITS

The primary health care benefits of the Belgian health care insurance system consists of cash refunds of part, and, in some cases, the whole of the cost of care. The extent of patient participation in the cost of care (regulated by the ticket moderateur) and the list of exempt client groups was set out in a preceding section (section B.3.1.3.3.). The extent of benefits is comprehensive in the general scheme and limited in the scheme of the self-employed. There are no duration limits on benefits.

As a general rule, the insured person is free to choose his doctor provided the physician is qualified to practice in Belgium and registered on the Medical Council's list. The doctor's pay is the result of negotiation between the profession, the funds and the hospitals. The community doctor and the hospital doctor is paid per item of service. The full fee is paid to him by the patient who them gets a refund from his fund at the appropriate rate - generally 75% of agreed tariffs. Specialist care is available out of hospital on the same financial basis although some services provided by specialists (e.g. X-rays and other diagnostic tests) are reimbursed only if they are carried out in hospitals under the 'proper conditions'. Dental care is provided on the same basis although false teeth are only available on these terms after the patient has reached the age of 50.

The cost of pharmaceutical products are partially reimbursed. A distinction is made between drugs made up in the pharmacy (magistrals) and branded drugs (specialties). For magistral drugs the beneficiary has to pay BFR 25 and for specialties BFR 60. The cost of specialties are reimbursed only if they are on an approved list and for the chronic sick the prices are reduced to zero and BFR 35.

The costs of hospitalization is met fully by the funds (although 25% of the cost is paid by the State) for the first 40 days of

treatment. Since 1964 legislation has been in force to regulate the daily maintenance charge which public and private hospitals are permitted to charge. This charge covers depreciation, administration, hotel costs, nursing and maintenance staff costs but excludes payments for drugs and physicians' services. The patient can elect to have superior (hotel) accomodation but is obliged to meet the costs of this out of his own resources.

The cost of accomodation has been raised to reduce social insurance costs. Since April 1978 patients in a room for more than 2 persons have been required to pay BFR 150 or BFR 250 per day from the 90th day in hospital. A charge of BFR 50 from the 41st to the 89th day is being maintained. Also the charges for superior hotel accomodation have been raised for each day of care.

The Cross Organizations (e.g. Yellow and White-Cross) are organizations which provide social workers, home nursing, preventative care and propaganda to members who contribute BFR 200 to 600 per year per family.

B.5. RESOURCES

This section is concerned with the quantity, price and distribution of a limited subset, doctors and hospital beds, of the total array of inputs which go into the health care process.

B.5.1. Doctors

Table 4

The doctor stock in Belgium 1960, 1970 and 1975

	1960	1970	1975
TOTAL NUMBER	11 380	14 991	17 983
Number per 100 000 population	125	155	176
Number of medical school graduates	(609 in 1965/6)	748	1 227

As can be seen from table 4 the doctor stock is growing quite rapidly. The number of medical school graduates rose from 609 in 1965-66 to 1 227 in 1975.

Table 5

1 January of each year	Number of hospitals			Number of beds			Beds of 1 000 inhabitants		
	public	private	total	public	private	total	public	private	total
	Acute general hospitals								
1967	111	256	367	17 401	26 044	43 445	1.83	2.74	4.57
1971	110	227	337	18 694	27 134	45 828	1.94	2.80	4.74
1977	103	194	297	21 431	29 836	51 267	2.18	3.03	5.21
	Psychiatric hospitals								
1971	12	66	78	6 193	20 360	26 553	0.64	2.11	2.75
1977	14	61	75	5 717	19 381	25 098	0.58	1.97	2.53
	Geriatric hospitals								
1971	17	16	33	2 400	885	3 285	0.25	0.09	0.34
1977	45	40	85	5 254	2 874	8 128	0.53	0.29	0.82

This growth is uncontrolled and unplanned. Entrance to medical school is available as of right to all students who fulfil certain minimal entrance requirements. It is estimated that by 1980 there will be 238 doctors per 100 000 population.

B.5.2. Hospital beds

Table 5 lists some of the characteristics of the Belgian hospital stock. Table 5 indicates that about 65% of general hospital beds are in private establishments, most of which are non-profit making. The characteristic of both the private and the public hospital sector is that the units are small.

The average length of stay for acute cases in 1962 was 12.9 days. it went up to 14.2 days in 1968 and down to 12.6 days in 1976.

B.5.3. Distribution

Tables 6 and 7 give details of the geographical distribution of doctors and hospital beds in Belgium.

The doctor stock has increased 125 per 100 000 in 1960 to 176 per 100 000 in 1975: Limbourg was the worst endowed area in 1960 and 1975. Brabant was the best endowed area in 1960 and 1975.

Table 6

The distribution of doctors in Belgium 1960 and 1975

Province	Number of doctors per 100 000 population	
	1960	1975
Antwerp	102	134
Brabant	188	264
West Flanders	86	137
East Flanders	101	147
Hainaut	115	158
Liege	157	218
Limbourg	62	93
Luxembourg	85	125
Namur	134	188
TOTAL	125	176

Table 7

The distribution of hospital beds in Belgium per 1.1.1977[1]

Province	acute	special	geriatric	sanatorium	psychiatric	total	per 1 000 inhabitants
	a	b	c	d	e	a/e	
Antwerp	8 469	88	1 152	80	4 722	14 511	9.28
Brabant	10 176	595	1 604	731	3 464	16 570	7.45
West Flanders	6 881	877	593	126	2 723	11 200	10.43
East Flanders	7 426	51	992	101	5 175	13 715	10.34
Hainaut	7 659	16	1 728	114	2 928	12 445	9.44
Liege	4 641	463	1 260	77	1 683	8 124	7.95
Limbourg	3 645	47	363	-	2 451	6 506	9.40
Luxembourg	643	-	211	-	80	934	4.25
Namur	1 727	-	225	-	1 902	3 854	9.83
BELGIUM	51 267	2 137	8 128	1 229	25 098	87 859	8.94

[1]Source: Ministere de la Sante Publique: 'Premiers et principaux resultats statistiques de l'enquete dans les établissements de soins'.

The distribution of hospital beds is also unequal and a cause for concern for policy makers.

Since 1963 the Minister of Public Health and Family Affairs has had the power to recognize a hospital or a hospital service. Such recognition is important as it affects access to social insurance monies and if recognition is withdrawn the hospital unit has to close. Since 1973 it has been forbidden to build, extend, convert or carry out works on a hospital or a service in a hospital. A consultative mechanism of the three Regional Committees of Hospital Programming and the National Committee of Hospital Programming has generated maximum bed-population ratios (and birth-population ratios for obstetric and child services) which have been turned into law by Royal Decrees in 1976 and 1977. Also the installation of 14 categories of heavy hospital equipment are subject to prior approval by the Minister.

The Government can also influence the distribution of beds by subsidies. By granting or withholding a subsidy - which amounts to 60% of building costs for local authorities and 50% for private institutions - the Ministry has sought to achieve the distribution targets of its hospital plan.

However, the efficacy of these policies has been vitiated by political pressures which have led to the over-ruling of unpopular decisions.

Recent legislation (1978) has given the Minister power to approve the integration of home nursing, community medical care services and homes for the elderly. This power is aimed at providing better community care, fewer admissions to hospital, and a reduced length of stay in hospitals.

B.5.4. Tariffs

B.5.4.1. Doctors

The fees paid to doctors are determined annually by national commissions, consisting of equal representation of the doctors, the sickness funds and the institutions providing care. The agreed fees can be accepted or rejected by each member of the profession. If within 30 days, the doctor does not signify objection to the proposed level of fees it is assumed that he agrees. Any agreement can be imposed by the Minister if 60% of the profession in the region accept it. If no such agreement is reached a commission may review the situation and impose a level of fees. The agreed fees are the basis for social insurance reimbursement but may be less than the fees charged by the physicians.

The fee scale covers medical acts by doctors in primary care work and hospital work, e.g. the 1976 fee for a consultation with a GP is BFR 160. The usual reimbursement rate for these fees is 75%.

B.5.4.2. Hospital fees

As indicated above the hospital daily rate fee is paid by the sickness fund but does not include the costs of the services of doctors and the cost of drugs. In August 1977 the Minister laid down the maximum rates of increase he would approve for particular classes of hospital and hospital service. The Minister can also affect fees by regulating staffing levels. The Government controls directly local government beds and in August 1977 laid down maximum ratios for nursing staff to beds for all general and psychiatric beds.

C. HEALTH CARE IN DENMARK

C.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

C.1.1. Evolution

The first national law to affect the finance and provision of health care in Denmark was enacted in 1892. This legislation was revised and expanded in 1968, 1969,1973 and 1974.

C.1.2. Administrative structure

C.1.2.1. Government

The responsibility for financing and providing health care in Denmark is divided up amongst three levels of government: the central government, the counties (amtskommuner) and the munipalities (Kommuner). Denmark is divided into 14 counties with a population of 250 000 to 500 000 each. Each county is divided up into a number of municipalities of which there are 275 in Denmark as a whole including Copenhagen and the neighbouring municipality of Frederiksberg which have had special status for over 100 years.

Each local government unit is governed by a council whose members are elected for four years and which has the power to levy a land tax and a proportional income tax. The revenues of these bodies is augmented by block grants from central government.

The freedom of the local government units is circumscribed by central government legislation. The central government determines which services will be provided by local government and also often determines the quantity and quality of provision. For example, the 1969 Hospital Act obliged each county to establish and operate a sufficient number of hospitals and convalescent homes for its population and compelled them to offer hospital services free of charge to the population. Also the Act required each county to prepare a detailed plan about the operation and future development of its hospital system. This plan has to be submitted to the central government for approval and

until the plans are drawn up and approved all new developments have to have the prior agreement of the Copenhagen authorities. Other legislation has compelled the municipalities to provide a home nurse and a visiting paediatric nurse service and to provide adequate dental facilities to furnish preventive and curative dental care for all children. Legislation in 1976 transferred responsibility for psychiatric care from central government to the regional (county) government authorities.

Some other health care activities are carried out also by the regional government. Regional and national government provides care and rehabilitation for alcoholics, epileptics, the blind and the deaf. In time central government will control only the Copenhagen University hospital (the most specialized unit in Denmark) the Finsen Institute, and the national diagnostic microbiological centre (Staters Seruminstitut).

The relationship between the Government and the doctors is governed by several bodies. Each county appoints a committee of four to six members whose objective is to facilitate cooperation and coordination between physicians, hospitals and the other health and welfare services. In addition there is a Central Negotiation Committee of seven councillors which is responsible for the conclusion of agreements with the professional bodies of doctors, dentists and other health care professions. These agreements have to be confirmed by the Ministry of Social Affairs. The supervision of the interpretation of these agreements is carried out by a committee consisting of three members of the Central Negotiation Committee and three representatives of the Danish Medical Profession. Similar machinery has been created for some of the other health professions. Where the parties fail to agree, arbitration machinery takes over and its decision is binding on both parties. It is to be noted that whilst general practitioners are in private practice, hospital physicians are government employees.

The two central government Ministeries supervising this set of administrative arrangements are the Ministry of Social Affairs and the Ministry of the Interior. As the Ministry of the Interior is concerned largely with the supervision of local and regional government most of the health care system is in its domain. The Ministry of Social Affairs is involved in the regulation of professional fees and the provision of health care services which have not, as yet, devolved to local government. Neither of these ministries employs members of the health professions. All professional advice is provided by the National Health Service. This institution is directed by a doctor and offers health care advice to all the ministries and the local government authorities involved in the planning, organization and management of the health service.

C.1.2.2. Sickness funds

All sickness funds were abolished on 1 April 1973, when the regional (county) and local authorities took over the role of primary financer and providers of health care.

C.1.2.3. Other

Because the Danish health care system has two membership categories, group 1 and group 2, one of which gets health care benefits equal to only part of the cost of primary care, there is a private health care insurance market. This is declining in importance as the size of the partially covered category declines.

Private health care is available in a couple of private hospitals. These hospitals are regulated closely by the government which usually finances much of the care which is given.

C.2. COVERAGE

Since 1973 the coverage of the Danish health care system has been 100%. There are two membership categories. Group 1 membership entitles the person to comprehensive health care at almost zero cost. Group 2 membership entitles the person to get free hospital care, limited reimbursements for primary care and a free choice of doctor in primary care. The dividing line between the two types of members used to be defined by a means' test but since April 1976 there has been a complete free choice between Group 1 and Group 2 membership. In October 1977 91.4% had group 1 membership and some groups are advocating 100% group 1 membership.

C.3. FINANCE

C.3.1. Income

C.3.1.1. Public finance

Since 1973 the Danish health care system has been tax financed. The counties can levy a proportional income tax at whatever rate they think necessary. The use of the other local taxation instrument, the land tax, is limited by agricultural pressure groups and the maximum tax rate that can be levied is limited to 2% of the value of the estate.

The central government uses a system of grants to equalize and supplement local resources. The grant system is based on a notion of 'demands and needs'. A formula which incorporates population, age structure, and load variables is used to provide block grants to the local authorities. In 1976/77 approximately 40% of the counties' expenditure was met by such block grants.

Table 1

Danish expenditure on medical care 1971/72 and 1977

(Mio DKR)

	1971/72	1977
1. Primary care		
Physician's fees[1]	730	1 600
Dentists' fees	360	600
Pharmaceutical products	340	565
Preventive services	100	240
School health	110	150
Domiciliary nursing	110	225
TOTAL	1 750	3 280
2. Hospital care		
General hospitals	3 600	8 770
Psychiatric hospitals	520	1 300
Somatic specialized hospitals	180	500
TOTAL	4 300	10 570
3. Total current expenditure (1 + 2)	6 050	13 850
4. Capital expenditure		
Hospital construction	870	870
Equipment	120	?
TOTAL	990	870
5. Total expenditure (3 + 4)	7 040	14 720

[1]Group 2 expenditure on physician's fees was probably about DKR 30 to 40 million in 1977

C.3.1.2. Private finance

In 1977 it was estimated that general practioners increased their earnings by 12 to 18% from private (Group 2) fees.

C.3.2. Expenditure

C.3.2.1. GNP

According to the official Danish estimates 3.8% of GNP spent on health care in 1966, 4.8% in 1971, and 6.1% in 1975.

C.3.2.2. Expenditure characteristics

Danish central government can control local government expenditure on health care in at least two ways. Firstly it can control the level of the 'block grant' to affect local spending power. Secondly it can control the entry of doctors into the health service by restricting the number of available established posts for general practitioners and hospital doctors.

C.4. BENEFITS

The health care benefits of the Danish system are comprehensive and free of charge for Group 1 members who are required to register with a specific general practitioner for at least a year. Group 2 members receive free hospital treatment and are free to choose their general practitioner or a practising specialist. The fees of the general practitioner for Group 2 members are largely paid by the government. A small amount (about 12 to 18% on average) is paid by the Group 2 patient.

Primary care is provided by general practitioners, the majority of whom are either in joint practice or a group practice. Some practices have auxiliary personnel work in them. In all there are 2 724 general practitioners working in 1 600 practices and having a total of 5 800 personnel working with them.

Hospital care is provided in 155 general hospitals and related institutions.

Pharmaceutical products are provided by a privately owned system of pharmacies and drug prices are regulated. The patient pays 25 to 50% of the cost of pharmaceutical products depending on the category of drug.

C.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. Although this is only a partial picture of the resource situation the statistics provided highlight some important policy issues whose character is similar to those existing in other member countries of the EEC.

Table 2

Regional distribution of doctors in Denmark in 1976

Region	Number of Doctors per 100 000 population	
	Hospital	General practitioners & practising specialists
Copenhagen municipality	241	74
Frederiksberg municipality	227	70
Copenhagen county	113	70
Frederiksberg county	81	67
Roskilde county	59	51
(capital region)	146	67
West Zealand county	96	61
Storstrøms county	99	63
A Zealand & Lolland-Falster total	136	66
B Bornholm county	60	77
C Funen county	102	63
South Jutland	62	63
Ribe county	75	59
Vejle county	82	61
Ringkøbing county	63	56
Aarhus county	126	65
Viborg county	88	61
North Jutland county	85	61
D. Jutland	89	61
A-D TOTAL (=DENMARK TOTAL)	111	64

C.5.1. Doctors

There are 9 900 doctors in Denmark (195 per 100 000 population). This total is made up of 5 634 hospital doctors, 2 724 general practitioners, 523 practising specialists, and 1 019 public health and research doctors. This stock has been growing at an average annual rate of 5% for hospital doctors and 5.5% for general practitioners since 1974.

The medical school intake is 800, since 1976 this has been on a quota basis, but only 600 graduate. There is unemployment amongst newly graduating doctors. The teaching costs of students are paid by the State but students have to finance their own maintenance from private resources or loans which are repaid later and on which the interest rate is 17%.

Table 2 shows the geographical distribution of doctors (hospital doctors and those in the community) in 1976. The capital region (included in A) is the best endowed region as far as hospital doctors are concerned. Roskilde has the lowest stock of GPs and practising specialists. The region variation in the stocks of doctors is quite substantial.

C.5.2. Hospital beds

Table 3 shows the distribution of general (and psychiatric) beds in Denmark in 1977. As it is difficult to relate the number of psychiatric and other beds to any particular county as far as the population catchment area is concerned the figures for these stocks is given only under the Danish total row.

The average length of stay was in 1966 was 12 days for surgical care, 15 days for medical cases, and 148 for psychiatric treatment. In 1976 the average length of stay was 8.5 days for acute care, 13.3 days for medical care, and 29.3 days for psychiatric treatment.

C.5.3. Distribution

It can be seen from Table 2 and 3 that the geographical distribution of doctors and hospital beds is unequal. The best endowed area is the Copenhagen municipality for doctors and also for hospital beds. The least well endowed area for doctors is Roskilde county and also for hospital beds. The government is seeking to equalize the distribution of doctors by controlling the establishment of posts and by financial incentives. The government is seeking to achieve hospital bed norms of less than 6.6 (per 1 000 population), short term beds, perhaps only 5.5. For psychiatric and other institutional beds there should be no increases. Indeed the stock should decline with the development of community care. The central government is trying to manipulate resources to achieve the following targets:

surgical beds	2.40
medical beds	2.00
pediatric beds	0.55
psychiatric beds	1.30
long term beds	0.90
regional specialty beds	0.85
other beds	2.50
TOTAL	10.50

Table 3

Regional distribution of hospital beds in Denmark in 1977

Region	Number of beds per 1 000 population			
	short term	Psychiatric	Other	Total
Copenhagen municipality	12.2			17.4
Frederiksberg municipality	14.5			14.5
Copenhagen county	4.7			6.5
Frederiksberg county	5.2			9.0
Roskilde county	3.1			3.1
(capital region)	7.4			10.2
West Zealand county	9.3			18.1
Storstrøms county	5.8			11.6
A Zealand & Lolland-Falster total	7.5			10.7
A Bornholm county	5.8			5.9
C Funen county	6.3			8.3
South Jutland county	5.1			6.7
Ribe county	5.7			11.2
Vejle county	6.6			10.1
Ringkøbing county	5.6			5.6
Aarhus county	6.5			8.9
Viborg county	5.9			10.7
North Jutland county	5.3			7.9
D. Jutland	5.9			8.6
A - D TOTAL (= DENMARK TOTAL)	6.6	2.0	1.9	10.5

C.5.4. Tariffs

C.5.4.1. Doctors

The fees paid to general practitioners are on a capitation basis with additional fees paid for certain types of service and out-of-hours care. The hospital doctor is paid a salary. Doctor remuneration is negotiated in the administration machinery outlined above (C.1.2.).

C.5.4.2. Hospitals

Hospitals are financed out of taxation.

D. HEALTH CARE IN THE FEDERAL REPUBLIC OF GERMANY

D.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

D.1.1. Evolution

The first national law to affect the provision of health care in Germany was enacted in 1883. The current legislation starts from the 1911 insurance code which has been amended many times during the last sixty-seven years.

D.1.2. Administrative structure

D.1.2.1. Government

There is a tripartite administrative structure of the health care sector in the FR of Germany. At the apex of this structure are the Federal Ministry of Youth, Family and Health Affairs and the Federal Ministry of Labour and Social Affairs which concern themselves with the general supervision of the health care system. The next tier is the Land (or State) Ministry of Work and Social Welfare which is responsible for the enforcement of the law and regulations of the Land. The Land is responsible for administering the health services. The lowest administrative authorities are the local boards of health which are affiliated to the local authorities. These boards are in charge of caring for specific groups (e.g. the handicapped, the chronic sick, addicts etc.), provide specific services (school health, public health and sanitary inspection) and supervise all hospitals.

D.1.2.2. Sickness funds

The majority of the population - some 90% - are members of a social insurance fund. All workers below an earnings ceiling are compelled to join the health care social insurance scheme and other may join on a voluntary basis. There are 1 425 sickness funds and these are divided into 8 groups:

307 'Ortskrankenkassen' (local sickness funds), 921 'Betriebskrankenkassen' (industrial sickness funds), 161 ' Innungskrankenkassen' (artisans' sickness funds), 19 'Landwirtschaftliche Krankenkassen' (agricultural sickness funds), 1 'Seekrankenkasse' (Seamens' sickness fund), 1 'Bundesknappschaft' (miners sickness fund), 7 'Ersatzkassen' for manual workers.

The sickness funds are grouped into 8 land and 1 national federation. They are self-governing bodies with a board of directors and an assembly of representatives who are chosen from the insured and employers, except in the case of the substitute funds whose directors come from the ranks of insured only. The funds provide roughly the same range of benefits. Those people who are not covered by the social insurance scheme and who are without private insurance cover or the means to buy health care, are eligible for benefits under the social aid programme. Social aid can meet the full cost of care and is means tested, it covers about 1% of the population and is administered by each Land.

D.1.2.3. Other

Those not covered by social insurance and the social aid provision of the Land have to depend on private insurance and private resources. This together with the fact that those covered by social insurance can 'supplement' their State benefits from private income, means that there is a substantial private insurance market for health care in the FR of Germany. The Association of Private Sickness Insurers (Cologne) has 37 members (of which 9 are limited liability companies).

D.2. COVERAGE

The German social insurance scheme covers about 93% of the population. Practically all employees, (i.e. all blue collar workers and white collar workers, below the earnings ceiling, farmers and their dependents working with them, and some self-employed groups, are obliged to contribute to the compulsory health care scheme. The unemployed's contribution are paid for him by the unemployment scheme. Since July 1977 pensioners are obliged to be registered with sickness funds. However their health care insurance is free only if they were insured with the statutory social insurance scheme for at least half the period between 1.1.1950 and their request for retirement. Those not meeting this criterion have to pay contributions if they wish to receive health care benefits. The criterion which determines contribution and membership is remuneration: i.e. all wage earners and self-employed who earn less than DM 2 775 per month are covered by the social insurance arrangements. White collar workers earning in excess of this ceiling can become voluntary members of the social insurance scheme. (At present about 86%

of the statutory scheme's members are compulsory members and 14% are voluntary members). Another important point to note is that as the ceiling rises (e.g. it rose from 2 550 (January 1977 figure) to 2 775 on 1 January, 1978) more employees are 'captured' by social insurance coverage. However when 'captured' these workers have the choice of joining the social insurance scheme or agreeing to take out (compulsory) private insurance coverage. On 1 January, 1977 approximately 79% of those people who had only just been covered by the statutory scheme, took this option. The number contracting out in this way has risen markedly since the early 1970s and is a reversal of practice at the beginning of the decade.

The percentage of the population covered by compulsory social insurance has increased considerably since 1966, when 86.4% of the population were covered.

D.3. FINANCE

The German health care system is financed from five sources: compulsory sickness funds, (the principle source of funds) private insurance organization, private voluntary organizations, public funds, and private resources. The sickness funds have to try to balance income and expenditure by estimating the costs in future periods and adjusting, subject to government agreement, the contribution rates of the insured. The funds finance hospital and primary care by contracting with the providers and financing them directly.

D.3.1. Income

D.3.1.1. Contributions by the insured

The contributions of the insured are not assessed on full but on insurable earnings i.e. earnings up to the ceiling of DM 2 775 per month. Since 1970 the earnings ceiling has been automatically adjusted to a level of 75% of the ceiling of the old age and disability scheme. The latter is adjusted via an agreed formula related to changes in wages and prices.

Contribution rates vary between the eight groups of sickness funds from 7.0 to 14.2%. The average contribution rate is 11.5% (January 1978) and this levy is divided equally between the employer and the employee. These contributions finance benefits in kind (health care) and in cash (sickness, maternity and death benefits).

D.3.1.2. Government contributions

At present the sickness funds have autonomy in fixing the contribution rates but the State is increasingly interested in containing costs by controlling contribution rates. Contributions to the finance of health care come from the Land (State) and the Bund (Central) government. The Bund makes contributions to maternity insurance and subsidizes the mine workers' scheme, the pensioners scheme and the schemes for special insured groups (e.g. students and the armed forces).

The Bund and the Lands have become increasingly involved (since 1972 on legal basis) in measures aimed at meeting the deficits of the hospital service and improving the quality and geographical distribution of hospital facilities. The flow of Bund and Land resources into the health care system has risen rapidly in the recent past. In 1977 the Bund contributed DM 13 400 million to the pensioners' scheme for blue collar workers, DM 3 200 million to the pensioners' scheme for white collar workers, DM 7 000 million to the miners' scheme for pensioners. Also the Bund directly paid DM 1 100 million to the health insurance system and financed hospital subsidies equal to DM 800 million. The Land and local government units contributed DM 1 600 million towards the cost of health care in 1977.

D.3.1.3. Private finance

D.3.1.3.1. Private insurance

In 1977 the expenditure of the private insurers in financing reimbursement of members' medical expenses was DM 4 790 million.

D.3.1.3.2. Pricing

Private insurance is used to finance the expenditure of those with no social insurance cover. Also many people (5%) with compulsory social insurance cover elect to have 'superior' treatments (e.g. superior hospital accomodation in small wards or private rooms rather than in large wards (standard 3rd class cover)). Those covered by social insurance get benefits in kind (i.e. there is no third party pays system as in e.g. France) and direct contributions by patients towards treatment costs are limited. The insured pay DM 1 per item for pharmaceutical products and spectacles. (children and veterans are exempt) The insured also pays part of the cost of appliances and for some types of dental care e.g. 20% of the cost of crowns. The latter change was introduced in 1977 together with changes which resulted in the non-reimbursement of certain minor medicines. These changes were part of a programme attempting to contain the costs of the social insurance programme.

D.3.1.3.3. Private resources

A large number of people have supplementary and basic private insurance. However it seems that some people supplement their social insurance benefits and purchase care out of private resources. No official estimates of this resource flow are available.

D.3.2. Expenditure

D.3.2.1. GNP

According to official estimates the percentage of GNP spent on health care was 4% in 1966, 5.7% in 1971 and 8.0% in 1976. (Some estimates put the 1977 health care expenditure level as a percentage of GNP as high as 10%).

D.3.2.2. Expenditure characteristics

Aggregation of the expenditure statistics of all the sickness funds, the private insurers and private individuals is not attempted in this section. The objective is merely to give some indication of the expenditure pattern of the social insurance sickness funds and its rate of growth.

D.3.2.2.1. The expenditure pattern

The expenditure pattern of the sickness funds in 1966 and 1976 (1973) is set out in Table 1. The medical and dental expenditures cover the finance of care by professionals in residential practice.

D.3.2.2.2. Expenditure growth

The Germans recognize that cost containment is one of their main policy problems in health care. During 1976/1977 social insurance health care expenditure increased by 9.1% and 4.6%. Costs of hospital care rose by 9.6% in 1976 and by 5.9% in 1977.

Table 1

Expenditure pattern 1966 and 1976 (1973)

(Mio DM)

Type of expenditure	1966	1977	(1973)
Medical and dental (treatment)	5 109	17 064	(10 799)
Medical appliances (equipment and drugs)	2 940	13 076	(9 871)
Hospital care	3 397	20 421	(11 307
Sickness benefits (cash)	3 791	4 874	(3 941)
Other [1]	3 125	14 898	(6 832)
TOTAL	18 362	70 333	(42 750)

1 Cash maternity and death benefits, administrative costs etc.

Source: Sozialbericht 1978, p. 102

D.4. BENEFITS

The health care benefits of the German social insurance system consist of benefits in kind which, in most cases, meet all the cost of care. The private insurance system gives benefits in cash.

In the event of illness the patient can choose his doctor freely from among the practising sickness fund doctors. The patient can also seek medical advice from a specialist registered with a fund if the patient so desires.

All doctors can enter a contract with a sickness fund to provide care for patients covered by social insurance. This relationship, between the fund, the doctor and the patient, is regulated by federal law. There is at least one doctors' federation (Kassenaertzliche Vereinigung) in each Land. All doctors treating sickness fund members are obliged to join one of these bodies and the federations are obliged by the sickness funds to meet the health care demands of fund members.

The patient who is a member of a sickness fund can choose his doctor (i.e. a general practitioner or a specialist) from amongst the practising insurance doctors. As proof of fund membership and as evidence of his right to claim free treatment, the patient must hand over a medical voucher'(Krankenschein) at the first consultation. These vouchers are issued to the insured by the funds which entitles the holder to claim the service of a doctor for three months.

The doctor receives his fee from the doctors' federation which in turn is financed by the individual sickness funds. The funds pay the federation an agreed amount and the federation generally distributes this money to individual doctors on a fee per item of service basis. The same procedure is followed for dental care.

Thus in the event of illness the patient can go to a general practitioner or specialist. If he is deemed to be in need of hospital care this usually involves in-patient treatment. Out-patient hospital facilities in Germany are unusual although efforts are being made to alter this aspect of health care provision. Hospital treatment financed by the funds can be carried out only in recognized hospitals listed in the 'Krankenhausbedarfsplan' (plan of hospital establishment requirements) which have contracts with the funds. Once in hospital the patients' ailment - if necessary - may be diagnosed anew: a wasteful duplication of doctors' time and testing procedures. The patient is usually provided with third class hospital accomodation and can purchase superior if he is prepared to pay for it.

D.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. Although this is only a partial review of the 'inputs' into the health care process it is useful because it provides insights into some important policy issues.

D.5.1. Doctors

Table 2 shows the regional distribution of doctors in the FR of Germany in 1976 and the national average statistic. The total doctor stock per 100 000 population in 1976 was 199.

The regional variations around this average are quite marked. If we set aside the special case of West Berlin, the best endowed area, Hamburg had a doctor stock over 63% above the national average and Niedersachsen, the worst stocked area, had an endowment over 16% below the national average. The city-Lands (Berlin, Hamburg and Bremen) tend to be better endowed with doctors than the non-city Lands.

Not only is the doctor stock in the FR of Germany high by European and indeed world standards, its rate of growth is rapid. Since 1972 a numerus clausus mechanism at the admission stage has provided Land and Bund authorities with a potential means of controlling the supply of doctors. A report commissioned by the Federal Ministry of Education (and produced by McKinseys) pointed out that with a medical school intake of 7 500 per year the doctor stock would rise to 285.7 per 100 000 population in 2000. However this level of medical school intake has been exceeded

(in 1977 the medical school intake was 10 500) and the output of medical practitioners from the medical schools in 1976 was 5 559. Although the Government has a potential means of controlling medical school intake it has proved difficult to use because of constitutional difficulties. The doctor stock in the FR of Germany is high, expanding and is, as yet, uncontrollable.

D.5.2. Hospital beds

The hospital system is structured on a Lander basis and hospital care is provided in a variety of institutional settings. With regard to acute care, the Land and local governments own 54.1% of beds (and 41.5% of hospitals). A further 41.9% of hospital beds are owned by voluntary bodies which own 40.5% of hospitals and 30.9% of beds are owned by private organizations (which own 18.3% of hospitals). Other hospitals which unite TB, chronic sick, psychiatric and handicapped cases etc. are owned in a similar pattern: the Land and local governments own 29.4% of units and 50.0% of beds; the voluntary bodies own 21.3% of units and 21.5% of beds; the private bodies own 49.1% of units and 28.4% of beds. Thus, as can be seen, private units tend to be numerous but small and the bulk of the care takes place in State and voluntary hospitals.

The total number of beds as at 31 December 76 was 726 846 in 3 436 units. There were 489 517 beds in the acute-care sector and 237 329 in the other sector. The statistics described in the preceding paragraphs are summarized in Table 3.

D.5.3. Distribution

Table 4 gives 1974 statistics for the distribution of hospital beds in the Federal Republic, acute-care bed statistics are given in the brackets. From both the total and the acute-care aspects, the Federal Republic has a large endowment of beds in 1974 there were 7.85 acute beds per 1 000 population. The geographical variations in the acute care stock were large: Schleswig-Holstein is the least well-endowed (5.82 per 1 000) and, outside West Berlin, Bremen is the best endowed (10.17 per 1 000 population). The Bund has passed legislation which provides public subsidies (paid ½ by the Bund, ⅓ by the Land and ⅓ by local government) to meet the investment costs of hospitals. (Hospitals requirements are listed in the Krankenhausbedarfsplan.) Similar finance is available for equipment. However the closing of hospitals in well-endowed areas is a problem which is being tackled now and which presents acute political problems.

Also the problem associated whith the regional inequality in the distribution of doctors is being tackled now by federal legislation.

Furthermore this large bed stock is used inefficiently. The average length of stay for acute cases in 1974 was 17.2 days and the average utilization rate was 84.1.

Table 2

Distribution of physicians in the FR of Germany 1976

Region	Number per 100 000 population	As a percentage of the German average
Schleswig-Holstein	184	92.4
Hamburg	325	163.3
Lower Saxony	167	83.9
Bremen	238	119.5
North Rhine-Westphalia	186	93.4
Hessen	206	103.5
Rhineland-Patatinate	179	89.9
Baden-Wuerttemberg	204	102.5
Bavaria	194	97.4
Saarland	192	96.4
West Berlin	341	171.3
FR OF GERMANY	199	100.0

Source: Wirtschaft und Statistik No 12, 1977, Statistisches Bundesamt Wiesbaden

Table 3

Hospital beds and units in the FR of Germany 1976: ownership characteristics

	Land and local government	Voluntary bodies	Private bodies	Total
Acute care beds	264 890	205 235	19 392	489 517
Acute care units	912	898	406	2 216
Other care beds	118 784	51 136	67 409	237 329
Other care units	359	261	600	1 220
TOTAL BEDS	383 674	256 371	86 801	726 846
TOTAL UNITS	1 271	1 159	1 006	3 436

Source: Wirtschaft und Statistik No 3, 1978, p. 185.

Table 4

Distribution of total hospital beds in the FR of Germany 1974

	Number of beds	Number of beds per 1 000 population
Schleswig-Holstein	26 521 (15 049)	10.26 (5.82)
Hamburg	20 280 (16 993)	11.70 (9.80)
Lower-Saxony	75 063 (53 029)	10.33 (7.30)
Bremen	8 851 (7 366)	12.23(10.17)
North Rhine-Westphalia	192 347(143 405)	11.17 (8.33)
Hessen	68 380 (38 521)	12.26 (6.91)
Rhineland Palatinate	43 185 (29 401)	11.71 (7.97)
Baden-Wuerttemberg	105 278 (65 466)	11.41 (7.10)
Bavaria	128 005 (81 311)	11.80 (7.50)
Saarland	13 394 (10 576)	12.14(19.59)
West Berlin	35 226 (25 209)	17.40(12.46)
FR OF GERMANY	716 530(486 326)	11.56 (7.85)

Source: Statistisches Bundesamt, Fachserie A, Reihe 7, Gesundheitswesen III 1974

D.5.4. Tariffs

D.5.4.1. Doctors

Doctors (specialists and GPs in the primary care sector are paid usually fee per item of service. In the case of doctors working for the sickness funds, the fees are determined by negotiations between the funds and the doctors' federations. The type of hospital doctors' pay varies according to ownership of the hospital. Doctors working in public hospitals are generally paid a salary and senior doctors (Chefarzt) can do private work. The same payment system operates in voluntary hospitals. In private units fees are charged by the doctor and paid by patients.

D.5.4.2. Hospitals

The total costs of the hospital are covered by daily hospital rates which are fixed by the Lander authorities in accordance with procedures laid down in the Federal Hospital Rates Order (Bundespflegesatzverordnung). These payments cover all hospital costs except the investment costs. In 1976 the average rate paid by the funds per day of treatment was DM 116.37 .

E. HEALTH CARE IN FRANCE [1]

E.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

E.1.1. Evolution

The first national social security law to affect the finance and provision of health care in France was enacted in 1928. This legislation was revised and expanded in 1945, 1960, 1967, 1971 and 1978 (the 1978 - 2 and 1978 - 4 bills).

E.1.2. Administrative structure

E.1.2.1. Government

At the national level the Ministry is involved, via the health map exercise (see below), in the central planning of hospitals, the subsidization of schemes, the fixing of doctors' fees and the pricing of pharmaceuticals. Each of the sixteen regions and ninety-five departments (plus four overseas departments) of France are involved to a certain extent in the finance and provision of health care. Each regional préfet is assisted by a Directeur régional de l'Action sanitaire et sociale and Médicin inspecteur régional (MIR). The departmental Préfet is assisted by similar departmental officials. These people are responsible inter alia for the finance and provision of the public health service (Santé Publique) and public hospital services.

E.1.2.2. Sickness funds

The majority of the population (all salaried workers in industry and trade) - over 75% - are compelled to join the general scheme (régime général).

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[1] This draft has been prepared with the assistance of Dr Bridgman and Dr Michel.

The rest of the population are covered by schemes for particular groups (special schemes) e.g. for miners, railway employees, seamen, agricultural workers and the self-employed. These schemes differ in scope and have developed independently.

The social aid public assistance aspects of health care administered after a means test at the departmental level of government provide health care for a small proportion of the population (2%) who have no social insurance rights.

The administrative structure of the funds varies and in the following exposition the characteristics of the general scheme will be considered. Under the general scheme, the National Sickness Insurance Fund (Caisse nationale d'assurance maladie), which is directly supervised by the Ministry of Health and Ministry of Finance, covers most of the industrial work force. The governing boards of the Fund, a private corporation in charge of a public service with financial autonomy, are responsible for the financial solvency of sickness, invalidity and death insurance on the one hand, and for industrial accidents and occupational diseases on the other hand. No cross subsidization between these two sub-systems and the systems for old age pensions and family benefits are permitted formally.

At the regional level there are 16 Regional Sickness Insurance Funds (Caisses régionales d'assurance maladie) which carry out a variety of functions.

The local or primary funds (Caisses primaires d'assurance maladie) are financially autonomous and number 121.

Where convenient, their area coincides with that of the department. These funds are responsible for the initial registration of members and dispense benefits. The primary funds may have local branches which serve particular areas.

E.1.2.3. Other

Private associations, limited companies and the mutual societies, provide additional health care cover. These companies provide insurance against risks which are only partly covered by the national system.

E.2. COVERAGE

France does not have one system of social insurance for health care. However the effect of the general and specific schemes is such that the schemes cover 98% of the population of France. The total number of contributors to social insurance schemes (specific and general) has grown from 14 680 million in 1968 to 19 664 million in 1977.

As the French social insurance system requires those covered to pay part of the cost of medical care benefits and as the degree of patient participation in costs has risen during the last few years, the private health care insurance coverage has grown.

E.3. FINANCE

Theoretically the sickness funds have to balance income and expenditure by estimating costs and income in future periods. The contribution rates of the insured is fixed by the Government in consultation with the sickness funds. The funds finance the payment of the hospitals and indirectly the payment of the health professions (doctors, nurses, pharmacists, midwives, dentists, physiotherapists etc.) and the drug bills of the insured.

E.3.1. Income

E.3.1.1. Contributions by the insured

At 1 June 1978 the contribution rate for those in the general scheme, levied on wages up to the ceiling of FR 48 000 per year, was 10.95% for employers and 3% for employees. The earnings ceiling is fixed annually by decree by using a coefficient resulting from a comparison of the general index of earnings reported by the Minister of Labour on 1 October of any year, and the same index as at 1 October, the year before. An additional levy of 2.5% is paid by the employer and 1.5% is paid by the employee is paid on total wage. These contributions are paid to finance benefits (in cash and kind) in cases of sickness, disablement and death.

The contribution rates to the special schemes differ from those of the general scheme, e.g. the non-agricultural self-employed contribute 7.65% up to the ceiling and 4% up to 4 times this ceiling.

E.3.1.2. Government contributions

Central government regulates investment in new hospital facilities according to criteria associated with regional disparities in hospital bed endowments (the departmental target is 5 acute beds per 1 000 population). Public hospitals can borrow money on the open market and can acquire subsidies from central government. They cannot, however, make a 'profit' (i.e. achieve surpluses of revenue over expenditure) and use this for investment.

Direct government subsidies are paid to the preventive services both public (departmental) and private (mostly the Red Cross).

E.3.1.3. Private finance

E.3.1.3.1. Private insurance

In 1976 the premium income for sickness (individual and corporate) of the mutual societies and the limited companies was FF 2 912 million (FF 1 678 million in 1969), an increase of about 20% over the 1975 income level.

E.3.1.3.2. Pricing

This private insurance cover was used to part-finance medical care provided under the social insurance scheme but not fully reimbursed under this scheme. The ticket modérateur determines the insured's participation in the cost of treatment and it varies for each type of treatment and standard of benefit received. The rate is fixed by Order in Council. The 1970 ticket rates were 30% of general and 10% of the cost of 'irreplaceable' or particularly expensive pharmaceutical products, 25% of the cost of visits, consultations and other services provided by doctors and other medical staff outside hospital, 20% of the medical service costs of practitioners and of tests in public and private institutions, 20% of the fee scale for the costs of hospitalization for short periods in public and private institutions, but nothing in cases of maternity and major surgical care.

The Government in an effort to reduce the public expenditure costs of the social insurance system and limit the rate of growth of the consumption of medical care has adjusted the ticket upwards in recent years e.g. in 1977 reforms resulted in 'irreplaceable' and particularly costly drugs being provided free and 'comfort' medicines (e.g. laxatives) being provided with the insured paying 60% of the cost (previously 30%, and at the same time the proportion of the cost of treatment paid by the insured for the costs of medical auxiliaries other than nurses, was increased from 25 to 35%.

Free health care (i.e. the ticket moderateur is zero) is provided under certain circumstances:

- if the insured or his dependents are hospitalized for more than 30 days, or if they undergo a major surgical procedure;

- when the insured person is in receipt of a supplementary allowance from the National Solidarity Fund;

- if the insured obtains an orthopaedic appliance of a nature specified in a decree;

- if the person is in receipt of a benefit for an illness which is included in the list established by decree on the advice of the Medical High Committee (in 1969 there were 21 conditions of this type), or has a prolonged and expensive illness;

- recipients of an invalidity pension or old-age pension paid to an invalid after his 60th birthday;

- those in receipt of industrial accident benefits who are certified at not less than 66⅔% incapable of work.

This exemption applies even if the recipient is in work and extends to his dependents.

Generally the patient pays the doctor and then is reimbursed, in part or in whole depending on his characteristics, by the local office or in the sickness of which he is a member. Hospitals are paid directly by the funds with contributions from patients as indicated above.

E.3.1.3.3. Private resources

Whilst about 50% of those who are compelled to be members of sickness insurance funds are also registered with a mutual society (private insurer), some are not exempt from the ticket and have no private insurance cover. As a result they finance the ticket out of their own resources. In 1974 CREDOC estimated that the flow of funds from private income and wealth was FF 17 500 million.

E.3.2. Expenditure

E.3.2.1. GNP

According to CREDOC's estimates the percentage of GNP spent on health care was 5.1% in 1966, 5.6% in 1971 and 6.7% in 1975.

E.3.2.2. Expenditure characteristics

Aggregation of the expenditure statistics of all the social insurance funds, the private insurers and private individuals, is not attempted in this section. The objective is merely to give some indication of the expenditure pattern of the general scheme and its rate of growth.

E.3.2.2.1. The expenditure pattern

The expenditure pattern of the general scheme in 1976 is set out in Table 1. Fees account for over 28% of the general fund's health care expenditure. The largest expenditure item is hospitalization which accounts for nearly 52% of the funds' total expenditure.

Table 1

General scheme expenditure on health care 1976

	Mio FF	%
Fees [1]	17 223.5	(28.3)
Drugs and appliances	10 327.4	(16.9)
Hospitalization	31 574.9	(51.8)
Other	1 743.7	(2.8)
TOTAL	60 869.5	(100.0)

1 Fees of practitioners outside the hospital (including doctors, midwives, dentists, pharmacists, nurses, physiotherapists etc.)

Source: Santé Sécurité Sociale No 1 1978 XIV Table IV a 2.

E.3.2.2.2. Expenditure growth

1977 was an unusual year in that it was characterized by a reduction in the rate of growth of expenditure. Table 2 shows the cumulative growth in expenditure in November 1976 and November 1977 compared with November 1975 and November 1976.

The data in Table 2 shows a marked fall in expenditure inflation in the year to November 1977 compared with the year to November 1976. The rate of growth of expenditure on fees and hospitalization fell by 38% and 42% respectively to 9.6% and 15.9%. Drug expenditure rose by only 1.8%.

Table 2

Expenditure inflation

	Annual percentage rate of growth	
	November 1976	November 1977
Fees	15.5	9.6
Drugs and appliances	5.7	2.2
Hospitalization	27.7	15.9
Other	15.0	11.2
TOTAL	19.5	11.6

Source: Santé Sécurité Sociale No 1 1978, XV table IV a 3.

The cause of this deceleration in the rate of growth of expenditure are diverse and not fully comprehended. The factors which are alleged to be important are: a reduction in medical consumption, greater awareness of doctors and administrators of the resource constraint, increased regulation of pharmaceutical costs and the reduction of value added-tax (VAT) on these goods, a reduction in the improvement of the hospital bed stock, fewer births, less immigration and the general environment of economic crisis which affected demanders and suppliers in the health-care system.

E.4. BENEFITS

The health-care benefits of the French social insurance consist of cash refunds of part of the cost of care. The extent of patient participation in the cost of care (regulated by the ticket moderateur) and the list of exempt client groups was set out in the preceding section (E.3.1.3.). The extent of the benefits is comprehensive and there are no duration limits on benefits.

Once a patient decides to visit a doctor his behaviour is regulated by a series of professional and government constraints. The Deontological Code (Decree of 28 November 1955) lays down the basic principles for the practice of liberal medicine in France: freedom of the patient to choose his doctor, freedom of the doctor to prescribe, medical confidentiality, direct payment of fees by the patient to the doctor. Thus typically a patient will choose which doctor to visit, will pay him the appropriate fee directly and get re-imbursement in part about a forthnight later (depending on the ticket moderateur) from the office of the local insurance fund.

Since 1971 the level of fees paid to doctors who whork outside hospital have been regulated by a national agreement. This agreement re-iterates support for the principles of liberal medicine and sets out the rates for various forms of treatment. The adjustement of these rates is discussed below (E.5.4.). At present the majority of such doctors in the community are parties to the fee conventions i.e. they charge the agreed fees. A minority of the profession (less than 5% are not covered by the conventions and charge higher fees. Also highly qualified doctors (les grands medecins) who are parties to the conventions may charge higher fees. Patients receiving treatment from such doctors get 75 to 100% of the agreed convention fee and pay any excess out of their own resources.

If the community doctor refers the patient to hospital the patient may get treatment in either a public hospital or a recognized (by the sickness funds) private hospital. Hospital treatment is provided by doctors different from those who do the initial diagnoses outside the hospital. This and the opportunity to acquire specialist treatment outside the hospital provides opportunities for duplication in diagnosis. The attributes of these two sections of the hospital system and the payment systems of the doctors employed in them are discussed below (E.5.2.). Again the cost to the patient of hospitalization is determined by the ticket moderateur. Non-exempt groups pay 20% of the cost of hospitalization up to a certain sum or nothing if the patient undergoes a major surgical operation (the lowest grade of such operations is a normal appendec tomy) or if the insured or his dependents are hospitalized for more than 30 days.

Post-hospital care is provided in nursing homes and in the private home and the reimbursement conditions are the same as those for hospitals. The costs of nursing care in the community are reimbursed in the same way as the costs of primary care.

E.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. Inevitably this is a partial picture of the nature of the inputs into the health care process, the supply of nurses, technicians and ancillary workers is ignored. Whilst these omissions are significant when considering the possibilities of substituting one factor for another (e.g. whether cheaper (?) nursing services can be substituted for expensive doctor services to provide the same health care outcome) they are unavoidable given our space constraints. The statistics provided highlight some important policy issues whose character is similar to those existing in other member countries of the EEC.

E.5.1. Doctors

Table 3 shows the regional distribution of doctors in France in 1975 and the national average statistics (with and without Paris). The total doctor stock per 100 000 population in 1975 was 146.5. However the geographical variations around this average are quite marked. Paris is the best endowed area with 218 doctors per 100 000 population (148% of the national average). The two least well endowed areas, Picardie and Basse-Normandie, have stocks 33% below the national average: 98 per 100 000 population.

At present a doctor is free to open an office anywhere in France. A doctor becomes a specialist as a result of passing examinations.

One defect in any analysis of stocks is that it gives little indication of its rate of change. The remarkable thing about the rate of growth of the French doctor stock is that it has been and is expected to continue to be very rapid and as a result it is estimated that by 1985 perhaps as many as 50% of the doctor stock will have been in practice for less than 10 years. Anyone who has obtained the baccalaureate can enter higher education in France. Medical education has proved popular and the number of training places in medical schools has expanded. Entry to medical education is restricted by a first and second year examination which equates the demand for places to the supply (in 1975 demand was 300 to 500% greater than supply). This method of regulation, enables the State after negotiation with the training institutions to affect the number of training places in medical schools. In 1977 the State responded to the threat of a doctor 'surplus' by cutting the number of post-first year training places by 20%.

Despite this cutback the effects of the lag between policy changes and policy effects (due to the length of the process of medical education) will mean that the doctor population stock is likely to exceed 200 per 100 000 in the 1980s.

E.5.2. Hospital beds

Hospital beds are provided by a variety of institutional arrangements: public institutions, private non-profit making institutions and private profit making institution (largely owned and operated by doctors and usually smaller than public hospitals). The public hospital system is structured and has 4 layers. There are about 900 public hospitals. Of these 28 are centres hospitaliers regionaux (CHRs with an average size in excess of 3 000 beds and with highly specialized facilities), 99 are 'hospitaliers regionaux' (CHs with an average size of about 600 beds with general surgical, general medical, maternity, radiology, paediatric, laboratory and outpatient facilities and facilities for the care of the chronic sick and those in need of rehabilitation), about 400 hospital units (with an average size

of about 170 beds and the same facilities as a CH except for chronic sick care and rehabilitation units) and about 370 rural hospitals (with an average size of about 30 beds and medical and maternity facilities only). Tables 4 and 5 present some relevant statistics for public and private hospital beds in France. Psychiatric beds in the psychiatric sector and nursing home beds are excluded from this data.

Table 3

Regional distribution of doctors in France 1975

Region	Number per 100 000 population	Endowment as a percentage of the national average
Paris	218.0	148
Champagne-Ardenne	104.6	71
Picardy	98.8	67
Haute-Normandie	105.5	72
Centre	111.8	76
Basse-Normandie	97.9	67
Burgundy	111.7	76
Nord-Pas-de-Calais	131.1	77
Lorraine	114.6	78
Alsace	136.8	93
Franche-Comté	102.9	70
Pays de la Loire	108.8	74
Brittainy	114.0	78
Poitou-Charentes	111.6	76
Aquitaine	149.9	102
Midi-Pyrénées	160.5	109
Limousin	122.5	84
Rhone-Alpes	129.4	88
Auvergne	127.6	87
Languedoc-Rousillon	190.6	130
Provence-Côte D'Azur	199.9	136
Corsica	148.7	101
TOTAL FRANCE (NATIONAL AVERAGE)	146.5	100
TOTAL FRANCE (EXCEPT PARIS)	129.5	88

Source: Santé Sécurité Sociale (1977).

These tables give data by specialty and by region for 1975 (for public units) and 1974 (for private units). In the public hospital sector Alsace is the best endowed area, 88 per cent above the national average of 4.98 beds per 1 000 population, and Nord-Pas-de-Calais the least well endowed (42 per cent below the national average). As far a private sector beds are concerned, Champagne-Ardenne is the least well endowed area (47% per cent below average) and Provence-Alpes Cote D'Azur the best endowed area, (87 per cent above average). A general

conclusion about the geographical distribution of beds in France is that it is similar to that of the doctor stock with areas such as Picardie, Nord-Pas-de-Calais and Basse-Normandie badly endowed and areas such as Paris and the Cote D'Azur well endowed.

During the period 1961 - 1975 the bed stock of the public hospitals has grown from 4.33 per 1 000 population to 4.98 per 1 000 population. In the period 1963 - 1974 the medical, surgical and maternity bed stocks of the private hospitals has grown from 1.77 in 1963 to 2.34 per 1 000.

The average length of stay in public and private hospitals in 1975 and 1974 was 14.7 and 24.0 days for medical cases and 10.4 and 9.4 for surgical cases (Santé Sécurité Sociale op.cit. Sept. - Oct. page 33 and Nov. - Dec. page 35). In 1967 the average length of stay in private hospitals was 28.1 days and 10 days for surgical cases (in 1968 the public sector figures were 22.4 and 13.6 days).

E.5.3. Distribution

In the preceding two sections the geographical inequality in the distribution of doctors and hospital beds has been indicated. The problems of the hospital sector has led to vigorous attempts to change the existing distribution of beds. The Hospital Reform Law (31 December, 1970) was passed to facilitate the creation of a public hospital service provided by public hospitals and approved private institutions. A health map of France, showing all facilities and their utilization rates, forms the basis of a system of planning whereby 'needs' are defined and resources are directed to those areas in greatest need.

E.5.4. Tariffs

E.5.4.1. Doctors

The fees paid to doctors who work outside the hospital are governed by the October 1971 national agreement. Each treatment mode is assigned a key letter and a coefficient which determines the payment level, i.e. the doctor is paid by performance or fee per item of service. Doctors in public hospitals paid in relation to the number and nature of medical acts that they perform. This remuneration is paid at a level between a minimum (floor) and maximum (ceiling) and tends to equate payment rates (However from the legal point of view they cannot be regarded as salaried).

Table 4

Public hospital beds 1975

(per 1 000 population)

Region	Medical	Surgical	Gynaecology obstetrics	Long Stay[1]	Psychiatric[2]	Total
Ile-de-France	2.28	1.22	0.29	0.95	0.20	4.94
Champagne-Ardenne	2.99	1.59	0.48	0.47	0.03	5.56
Picardy	2.03	1.21	0.47	0.35	-	4.06
Haute-Normandie	2.57	1.35	0.43	0.31	0.15	4.81
Centre	2.32	1.24	0.36	0.34	0.74	5.00
Basse-Normandie	2.99	1.51	0.52	0.43	0.75	6.20
Burgundy	2.95	1.43	0.43	0.57	0.22	5.60
Nord-Pas-de-Calais	1.84	1.11	0.33	0.12	0.10	3.50
Lorraine	2.49	1.38	0.40	0.47	0.21	4.95
Alsace	3.78	1.99	0.51	0.26	0.22	6.76
Franche-Comté	2.47	1.47	0.46	0.49	0.36	5.25
Pays-de-la-Loire	2.22	1.09	0.36	0.71	0.43	4.81
Brittainy	2.54	1.17	0.31	0.72	0.54	5.28
Poitou-Charentes	1.96	1.26	0.40	0.40	1.33	5.35
Aquitaine	2.11	1.12	0.34	0.54	0.22	4.33
Midi-Pyrénées	2.34	1.12	0.32	0.85	0.39	5.02
Limousin	2.46	1.25	0.42	0.56	0.04	4.73
Rhone-Alpes	2.83	1.42	0.44	0.51	0.10	5.30
Auvergne	2.44	1.35	0.36	0.68	0.69	5.52
Languedoc-Roussillon	3.02	1.24	0.23	0.39	0.91	5.79
Provence-Alpes-Cote d'Azur	2.52	1.41	0.29	0.39	0.26	4.87
Corsica	2.03	0.72	0.26	0.62	0.08	3.71
TOTAL FRANCE	2.45	1.29	0.36	0.56	0.32	4.98

[1]Long Stay other than psychiatric.
[2]Psychiatric beds in public hospitals.
Source: Santé Sécurité Sociale No 6, tome A (Novemver-December) 1977, p. 34.

E.5.4.2. Hospital fees

At present most hospitals charge on the basis of a 'daily rate' system. A law dated 4 January, 1978 legalized an experiment with new systems of charging. Two systems are being evaluated: that of 'spread out' daily rates and that of the total budget. Under the first system, the invoicing of expenses incurred is broken down into four parts (admission, accomodation, treatment and costly individual benefits). It is hoped that this system will permit decision makers to monitor cost movements more closely. The total budget system gives an annual budget to the hospital and the hospital then has to operate within this budget constraint. These innovations are being implemented in a limited number of public hospitals and will be evaluated over a period of years.

Table 5

Private Hospital Beds 1974

(per 1 000 population)

Region	Medical	Surgical	Maternity with surgical services	Maternity without surgical services	Convalescence	Rehabilitation	Mental illness	TB	Total
Ile-de-France	0.72	1.79	0.39	-	0.10	0.13	0.27	0.12	3.52
Champagne-Ardenne	0.13	1.11	0.22	-	0.04	0.11	0.05	0.04	1.71
Picardy	0.40	0.67	0.16	-	0.19	0.22	0.20	0.16	1.98
Haute-Normandie	0.29	0.93	0.21	0.01	0.22	0.14	0.09	0.12	2.02
Centre	0.46	0.89	0.19	0.01	0.54	0.09	0.38	0.15	2.70
Basse-Normandie	0.07	0.76	0.18	-	0.36	0.26	0.02	0.18	1.83
Burgundy	0.30	0.94	0.18	0.02	0.28	0.24	0.20	0.07	2.24
Nord-Pas-de-Calais	0.26	0.87	0.23	0.01	0.06	0.13	0.03	0.43	2.02
Lorraine	0.74	1.57	0.34	0.03	0.18	0.25	-	0.08	3.19
Alsace	1.05	1.14	0.14	0.02	0.83	0.19	0.18	0.23	3.78
Franche-Comté	0.20	0.81	0.28	0.01	0.28	0.02	0.01	0.07	1.69
Pays de la Loire	0.34	1.00	0.24	0.01	0.22	0.15	0.07	0.25	2.28
Brittainy	0.13	1.04	0.28	0.01	0.28	0.37	0.38	0.30	2.80
Poitou-Charentes	0.22	0.83	0.16	-	0.21	0.08	0.07	0.16	1.72
Aquitaine	0.74	1.23	0.29	0.01	0.54	0.35	0.68	1.05	4.89
Midi-Pyrenées	0.55	1.16	0.29	0.02	0.59	0.29	0.57	0.18	3.65
Limousin	0.40	0.71	0.10	-	0.19	-	0.13	0.14	1.67
Rhone-Alpes	0.52	1.08	0.24	0.01	0.57	0.24	0.43	0.70	3.79
Auvergne	0.10	1.06	0.18	0.04	0.19	0.03	0.24	0.58	2.41
Languedoc-Roussillon	0.86	1.58	0.34	-	0.85	0.95	0.73	0.65	5.96
Provence-Alpes Cote D'Azur	1.19	1.56	0.28	0.02	1.49	0.40	0.60	0.58	6.12
Corsica	0.52	1.59	0.28	-	1.09	-	-	-	3.49
TOTAL FRANCE	0.54	1.23	0.27	0.01	0.40	0.22	0.29	0.32	3.26

Source: Santé Sécurité Sociale No 5, tome 1 (September-October 1977, p. 28.

F. HEALTH CARE IN IRELAND

F.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

F.1.1. Evolution

The first national law to affect the finance and provision of health care in Ireland was passed in 1911. This legislation has been revised and expanded in 1947, 1953, 1960 and 1970.

F.1.2. Administrative structure

F.1.2.1. Government

The organization of the Irish health-care system was revised in 1971. The Department of Health in Dublin supervises the operation of the Irish Health service and carries out a long term planning function.

The task of administering the day-to-day running of the Irish health service has been devolved to eight Health Boards. These bodies consist of local authority elected members, who are in the majority, and representatives of the medical and ancillary health professions. The latter are elected by the professions, although the first representatives were appointed by the Minister. The Boards coordinate their activities with the local authorities and the voluntary health bodies. The work of the Boards is divided into three broad programmes covering respectively community care services, general hospital services, and 'special' hospital services (for the mentally ill, the mentally handicapped and geriatrics).

The community care component of each Board's work covers preventive health activities, general practitioner services, social workers, dental services, and public health nursing services. These services are administered at the local government level. Various local committees of the Board keep it in touch with local opinion.

In smaller Board areas one programme manager is responsible for the general and special hospital programmes dealing directly with hospitals in public ownership. In larger Board areas these two programmes each have a programme manager. The problem of coordinating the public and private hospital sectors is the responsibility of the three Regional Hospital Boards (Dublin, Cork and Galway).

The main problems which have arisen in this new administrative system are twofold. Firstly, the problem of coordinating and planning the private (voluntary) and public hospital systems has not yet been fully resolved. Secondly, there is a problem in coordinating the activities of the Health Boards and the local authorities who provide social services.

F.1.2.2. Sickness funds

There are no sickness funds in Ireland.

F.1.2.3. Other

Since 1957 a State-sponsored Voluntary Health Insurance Board (VHIB) has had a monopoly of private health care insurance in Ireland. In 1977 over 500 000 people were covered by some form of VHIB insurance.

F.2. COVERAGE

There are two major client groups in the Irish health care system: those persons on families with full eligibility and those with limited eligibility.

F.2.1. Full eligibility (the General Medical Service)

Those citizens with full eligibility status have the right to benefits under the General Medical Service (GMS) scheme. The citizen can acquire a GMS (medical) card if he cannot 'without undue hardship' pay for general practitioner medical and surgical services for himself and his family. The card is issued after a means' test based on normal pre-tax income (e.g. in 1978 a married couple with an income of not more than IRL 37.50 per week is eligible for membership of the GMS). At the end of 1977 almost 39% of the total population were in receipt of benefits under the GMS. There are large regional variations in coverage with high levels of cover in the west and lower rates in the east.

F.2.2. Limited eligibility

There are eight categories of limited eligibility coverage. The groups covered are essentially middle income groups (e.g. all non-manual workers earning less than IRL 3 000 per annum and all manual workers who pay insurance under the Social Welfare Social Insurance scheme are covered. The Department of Health estimate that 48% of the population have limited eligibility coverage.

Thus, in total, 87% of the population are included in the full and limited eligibility categories of Irish health care system.

This pattern of coverage will be radically changed from 6 April 1979 in accordance with arrangements announced by the Minister for Health on 26 July 1978. Under these arrangements the population will be divided into three eligibility categories. Category I will comprise those who now have full eligibility. No change is proposed in their entitlement to health services. Category II will comprise persons other than those in Class I with annual incomes less than IRL 5 000. This class corresponds broadly to the present limited eligibility category.

Persons in it will be entitled to the existing range of 'limited eligibility' services at public ward level free of charge except for the charges to be made by hospital consultants. They will also be entitled to specialist diagnostic and treatment services on an out-patient basis in public hospitals, the patients being responsible for payments to the consultants; also, refund of part of the cost of prescribed medecines.

These arrangements will be accompanied by the replacement of the present system of a flat rate health contribution by a system of earnings' related health contributions. All income earners will be liable to pay the contributions with the exception of medical card holders and persons in receipt of certain social welfare benefits. The rate of contribution will be 1% of income up to a 'ceiling' which will be IRL 5 000 a year in 1979.

F.2.3. Private cover

Over 500 000 people covered by private health care insurance provided by the monopoly, Voluntary Health Insurance Board.

F.3. FINANCE

F.3.1. Income

Health care is financed from general taxation. There is a very small contribution paid by those in the limited eligibility category (IRL 0.50 per week). There is no payment by employers. Charging is limited to pharmaceutical products. Voluntary health insurance income for the year to end February 1977 was almost IRL 12 million. The amount of private resources financing care is not known.

F.3.2. Expenditure

F.3.2.1. GNP

According to official estimates the percentage of GNP spent on health care in Ireland grew from 3.6% in 1966, to 4.7% in 1971, to 6.5% in 1975 and dropped to 6.08% in 1977.

F.3.2.2. Expenditure characteristics

In table 1 the expenditure characteristics, by spending authority and type, of that part of the Irish health-care system which is provided by the government is set out. The Health Boards, which finance public hospitals, the GMS and other functions constitute the major spending agency.

The major type of expenditure is hospital care: it is to be remembered that over 60% of the population get no primary care benefits (i.e. general practitioner service) from the government service.

Public expenditure on health services in 1977 grew by 0.48% in real terms. During the period 1974-76 expenditure was static. Voluntary Health Insurance claims for the year to end February 1977 was almost IRL 11 million. The amount of private expenditure on health care is not known. It is clearly quite substantial as the majority of the population have no primary care cover and 15% of the population (generally the most affluent) are outside the limited and full eligibility categories.

Table 1

Public expenditure by spending authority and type 1977

(Mio IRL)

(a) Expenditure by spending authority	
Health boards	227.0
Voluntary hospitals	70.5
TOTAL	297.5
(b) Expenditure by type	
General hospital care [1]	165 768
Psychiatric and mental hancicap hospital care	65 350
General medicine and the general practitioner service (including home nursing services, opthalmic, dental, aural services & drug costs)	45 492
Other	65 074
TOTAL	341 684

1 The figure given for General hospital care includes all expenditure on hospital care except psychiatric and mental hospital care. The breakdown of the figure is available. IRL 19 743 million of the total is attributable to long-stay hospitals.

F.4. BENEFITS

The 30% of the population who are card holding members of the General Medical Service (GMS) get a wide range of health care benefits. The card holder can apply for entry to the list of any physician who has agreed with the Health Board to provide general practice services. Once accepted by the physician the card holder is elegible for the same services as provided for private fee-paying patients. Most doctors in the west practice alone, but in the east group practices are more common. The card covers the cost of all prescribed pharmaceutical products made up by pharmacists who are members of the GMS. The card holder is eligible for free out-patient and in-patient care, provided the latter is in a public ward. Hospital care can be provided in any Health Board hospital or any other approved hospital. Home nursing services are available for all card holders, particularly the elderly. In theory free dental care is available, but in practice such care is often absent due to a shortage of dentists.

Opthalmic services are available free of charge, but waiting lists are sometimes long. The expectant mother with a medical card is entitled to a full range of care. Other benefits including hearing aids, walking aids, wheelchairs, a chiropody service and travel allowances for the ill and visiting relatives.

Those with limited eligibility status get no general practitioner benefits from the government schemes. They are eligible for free in-patient hospital treatment in a public ward and free out-patient treatment if the patient is referred by a doctor. The hospital used by this group of patients must be a Health Board or a Board approved institution. Those people who opt for private or semi-private hospital treatment get only part of the cost of such care. This balance must be paid by the patient or with benefits derived from the membership of the Voluntary Health Insurance Scheme. The costs of pharmaceutical products are covered in part for those in the Limited Eligibility Scheme and free maternity and infant welfare benefits are provided.

The Voluntary Health Insurance scheme offers two main types of policy: a policy for hospital costs and an optional policy to cover non-hospital bills. The latter costs IRL 3 per year but there is a deductible amount of IRL 25 per year (IRL 35 for a family). At present only 18 000 of the 500 000 covered by VHI have the latter type of policy. The rest of the population not covered by the GMS pay for non-hospital care out of their own resources.

F.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. These statistics give only a partial picture of resource stocks and flows in Ireland but they highlight some important policy issues whose character is similar to those existing in other members countries of the EEC.

F.5.1. Doctors

Table 2 shows the details of the doctor stock in 1966 and 1971. The total stock rose from 104 doctors per 100 000 population in 1966, to 120 in 1971. In 1977 it was 120 per 100 000 population. At present the Irish medical schools are producing annually 470 to 480 new graduates. In the past up to 70% of this output emigrated. The Irish Medical Association proposed a reduction in the medical school intake of 30% in 1977. Two of the four medical schools have agreed to cut their intake by 15% in 1979 and it is possible that the other two schools will emulate them.

Table 2

The distribution of doctors in Ireland[1]

Area	1966	1971
Eastern	154	174
Midland	70	76
Mid-Western	77	87
North-Eastern	69	77
North-Western	71	95
South-Eastern	72	75
South	99	111
West	88	110
Ireland	104	120

[1]Doctors per 100 000 population.

Table 3

The distribution of hospital beds in Ireland 1974[1]

Area	Acute beds	Psychiatric beds
Eastern	7.9	3.7
Midland	4.8	8.0
Mid-Western	4.9	5.3
North-Eastern	4.4	3.9
North-Western	3.8	7.0
South-Eastern	4.3	7.4
South	6.5	3.6
West	4.8	8.0
IRELAND	6.1	5.2

[1] Hospital beds per 1 000 population.

F.5.2. Hospital beds

Details of hospital bed stock are given in Table 3. The stock of acute beds in 1974 was 6.1 per 1 000 population and there were 5.2 per 1 000 psychiatric beds. The average length of stay for acute care in public hospitals in 1975 it was 11.3 days and in Voluntary Hospitals it was 11.3 days.

There are 158 acute hospital units in Ireland of which 98 are owned by the Health Board, 46 by the Voluntary Hospitals and 14 are private institutions. Of the total acute-bed stock of 19 473, 10 552 beds are in Health Board hospitals, 7 452 are in Voluntary Hospitals and 1 469 are in private hospitals. There are 11 private and 26 Health Board psychiatric hospitals and the total bed stock is 15 156 of which 14 082 are in Health Board units.

F.5.3. Distribution

Tables 2 and 3 give details of the regional distribution of doctors and hospital beds in Ireland. Significant differences in the endowments of the different regions are apparent. Official reports (e.g. the Fitzgerald Report 1968) have given some consideration to geographical inequalities in the distribution of hospital beds but the 1975 Hospital Plan said very little about this problem.

The distribution of doctors is being affected by government regulation of the General Medical service. Careful control is being exercised over the recognition of new GMS general practitioners despite the demand for free entry by the profession, the target is 1 doctor per 2 000 population. Entry to the GMS at present is by open competition for available posts. The distribution of hospital doctors is affected by the greater availability of private practice in the east of the country. The West areas have vacant posts which have not been filled due to the lack of adequate incentives.

F.5.4. Tariffs

F.5.4.1. Doctors

General practitioners in the GMS are paid by the Health Boards on a basis of fee per patient contract. Hospital doctors employed by the Health Boards are paid a salary. Those doctors working in the Voluntary hospitals are paid on a sessional basis for out-patient clinics and under a 'pool' system for in-patients (pool payments are payments per day for each public patient treated in the hospital. The 'pool' of these payments for each hospital is divided between the consultants on a basis agreed

amongst themselves). Hospital doctors can work part time in Health Board hospitals and practise privately.

F.5.4.2. Hospital fees

Health Board hospitals are financed out of general taxation on a budget basis. The Voluntary Hospitals used to be paid on a daily fee basis but now they are paid on a budget basis.

G. HEALTH CARE IN ITALY

G.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

G.1.1. Evolution

The first national law to affect the finance and provision of health care in Italy was enacted in 1943. This legislation was revised and expanded in 1962 and 1974.

G.1.2. Administrative Structure

The old health care scheme, provided by 200 sickness funds and giving limited during coverage to most of the population is being replaced with a comprehensive national health service. This process of replacement is incomplete and, as a result, the complexities of the Italian health care system are exacerbated.

G.1.2.1. Government

Three central government ministries are involved in the detailed running of the health service in Italy. The Ministry of Health regulates the provision of health care by the decentralized government units (the regions, provinces and municipalities) and allocates finance to the Regional authorities. The Ministry of Labour and Social Welfare regulates the sickness funds, which continue to exist as the finance collecting agencies and, to a limited extent, providers of health care. The Ministry of Public Works controls the (capital) finance of new hospital construction, except in the South where there is a special agency. Government subsidies for health care are the product of the interaction of the Ministry of Health and the economic ministries of the Rome government (there are separate spending (Treasury Ministry) and financing ministries (Ministry of Finance)).

The next layer of government is the regions. According to the principles of the scheme for the National Health Service since 1972 there have been 20 regions, varying in population size from 100 000 to 8 million, with the power to create and implement laws provided they do not contravene the Constitution or the 'fundamental' laws of central government. The regions finance from central government subsidies (but do not provide) preventive

health care services, a school medical service, vaccination and the training of auxiliary health personnel, and they distribute subsidies from the National Hospital fund to local hospitals.

There are 94 provinces in Italy and few have much political power. The main health care function of the provinces is to insure that the municipalities are able to provide health and welfare services and to provide care for psychiatric patients, to manage the public health laboratories, and to care for the unemployed with TB. In some ways their role is duplicated by the municipalities but to eradicate the provinces requires a change in the constitution.

The most important non-central level of government from the point of view of health care is the municipality. There are about 8 900 municipalities in Italy and they deliver preventative services (e.g. vaccination, the school health services (financed in part by the provinces)), clinics for municipal doctors (9 500 and midwives 3 000).

Public hospitals are independent public agencies which are governed by boards made up representatives of municipal provincial and regional government in accordance with the proportions of the political groups in these assemblies.

G.1.2.2. Sickness funds

Legislation passed in 1974 and 1977 will result in the abolition of the sickness funds and their replacement by a 'national health service' financed by earmarked taxation and provided by the Regional authorities and the professions. This reform is being implemented gradually and at present the funds continue to operate as agents of the State in collecting insurance contributions and, to a limited extent, as providers (e.g. INAM provides care in a network of Polyclinics).

Prior to the recent changes INAM was by far the largest fund covering 54% of the population. The three public sector schemes (ENPAS, ENPDEDP and INADEL) covered 15% of the population. The three schemes for the self employed covered nearly 21% of the population. These together with six other groups of small schemes covered 90% of the population. Coverage will be complete when the 1974-77 legislation is replaced by the National Health Service. This replacement is still being debated by the Italian Parliament.

The sickness funds are the contribution collecting agents of the State at present. Part of the money collected by the funds is distributed by the Ministry of Health to the Regions for hospital care. This allocation is a matter of dispute: there is no agreed formula as yet and allocations appear to be made on an ad hoc basis with regions able to meet deficits by extensive borrowing on the capital market. Doctors and pharmacists are financed

directly by the sickness funds with the contribution income which is not paid to the Regions, via the Ministry, for hospital care.

G.1.2.3. Other

Private insurance for health care is offered by four companies. Religious organizations are important in providing care (nursing services) and facilities (private hospitals).

G.2. COVERAGE

Italy has one system of health care in some respects. Nominally coverage is complete but the provision of facilities is very unequal and so coverage in different parts of the country can mean radically different things with regard to access to quality and quantity of health care.

G.3. FINANCE

The funds collect contributions and use part of this revenue to pay doctors and pharmacists. The rest of the revenue is paid to the Ministry of Health which allocates these funds to the Regions who are responsible for the finance and provision of the hospital services.

G.3.1. Income

G.3.1.1. Contributions by the insured

The insured person pays a contribution rate of 0.30% of his earnings (0.15% is paid to finance hospital insurance). The employers contribution rate varies from one economic sector to another. In the industrial sector a contribution of 7.70% for manual workers and 5.70% for staff is paid by employers. In commerce the rates paid are 6.20% for manual workers and staff and 4.70% for travelling salesmen and representatives. In the bank and insurance sector the rate is 4.70%. In all these sectors a contribution rate of 3.80% for pensioners and their dependents is paid by employers. Contributions relate to total earnings (i.e. there is no earnings' ceiling beyond which no additional contribution is paid). Lump sum daily contribution rates are paid in agriculture: for men LIT 119.76 per day, for women LIT 114.37 per day and for young people LIT 111.37 per day.

G.3.1.2. Government contributions

In the three schemes for the self-employed a fixed amount is paid by the central government for each insured person. At the moment, until the National Health Service scheme is passed, there are no substantial changes in the government finance of health care.

The National Hospital fund, created in 1974, finances hospital care for insured people. The responsibility for this task was transferred from the sickness funds to the Regional Authorities. 43% of all sickness fund contributions paid from employers and all other subsidy for the same purpose from other minor institutions and from municipalities or provinces, are paid to the National Hospital fund for distribution to the regions. At the same time (1974) a new contribution of 1.65% (1.50 employers, 0.15 workers) of earnings was introduced. This is paid to the National Hospital fund to help to meet the cost of hospital care. These funds are allocated every three months by the central government to the regions according to the provisions made for each hospital.

Provinces and municipalities are not directly involved in this problem of finance or in the payment of other expenses (medicaments, practitioners etc.) which are met by the sickness funds.

G.3.1.3. Private finance

G.3.1.3.1. Private insurance

In 1976 the premium income of the private insurance institutions was LIT 55 600 million. These premia generate benefits for health care and disability. The total insurance payments of the institutions was LIT 28 525 million in 1976 and it is not possible to identify the exact amount of this which financed health care.

G.3.1.3.2. Pricing

No prices are levied on health care benefits in Italy. All benefits supplied under social insurance are free of charge.

G.3.1.3.3. Expenditure

1) GNP

The official estimates of health care expenditure as a percentage of GNP are 3.2% in 1966, 4.3% in 1971 and 4.9% in 1976 (1974 + 5.7% = 5.2%).

2) Expenditure characteristics

Most expenditure is financed from monies collected by the sickness funds. The government contributes towards the cost of financing the hospitals and private individuals, via private insurance and their own resources, purchase superior types of health care benefit. No attempt is made here to aggregate these flows. The objective is merely to give some indication of the expenditure pattern of the sickness funds and its rate of growth.

a) The expenditure pattern - The expenditure pattern of the funds for 1975 and 1976 is given in Table 1. Expenditure on health care by the funds was over LIT 3 700 000 million in 1976 and the main items of expenditure were hospital care (51% of the total) and expenditure on drugs (27% of the total).

b) Expenditure growth - Between 1975 and 1976 the expenditure of the funds grew by over 21%.

Table 1

Medical care expenditure by the sickness funds, Italy 1975 and 1976

(Mio LIT)

	1975	1976	Growth (%)
Physicians fees (i) general medicine	450 872	488 477	8.3
(ii) specialist care	98 569	121 101	22.8
Hospital care	1 551 281	1 886 269	21.5
Pharmaceuticals	790 221	999 552	26.4
Out-patient care	163 014	209 139	28.2
Other health care expenditure	6 522	5 769	-11.5
TOTAL	3 060 481	1 710 309	21.2

NB: This expenditure represents only about 70% of total outlays. A further 26.54% of expenditure went on a sickness and maternity benefits, 3.75% on administration and the rest on a miscellany of activities (reserves, depreciation etc.).

Source: INAM, 'Notizie statistiche sull "attivita" svolta dall' INAM nell'anno 1976' Roma 1977 tav. 19 p. 33.

G.4. BENEFITS

The health care benefits of the Italian health care insurance scheme consist of benefits in kind. The extent of the benefits is comprehensive in principle and there are no duration limits on benefits.

The providers, doctors, pharmacists and nurses, have made agreements with the funds to provide services at given prices. The doctors working in the community are paid on a capitation fee basis whilst hospital specialists are paid generally on a part or whole time salary basis.

The patient has a free choice of doctor provided the one used is contracted to the fund. The patient may visit a general practitioner or a specialist, although access to the latter is usually regulated by the general practitioner and available only on certification of need by him. The fees paid are regulated by a national agreement (1978) between the providers and the financiers. Doctors are usually in solo practices. INAM operates polyclinics with group physicians (both general and specialized) together and the extension of group practice is favoured by the government.

G.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. This is recognized as being only a partial picture of the resource situation in the Italian health care system but selectivety is inevitable given space constraints.

G.5.1. Doctors

In 1965 the doctor stock was 89 500 or 160 per 100 000 population. By 1975 the doctor stock was 126 300 or 205 per 100 000 population. The stock has grown rapidly because of a policy of open entry to medical schools (all those who matriculate have the right to the higher education of their choice). The intake of Italian medical schools is 114 000 (1973) and the output of graduates is 5 400 per year (1972).

This growth of an already large doctor stock is uncontrolled and likely to create problems for Italy and other members of the EEC. The 1976 directive created an EEC market in doctors and doctor 'surpluses' may migrate despite language barriers and pay differentials.

Table 2

Distribution of Doctors (1975) (Number of Inhabitants per doctors.)

Bologna	259	Macerata	538
Rome	261	Campobasso	541
Genoa	278	Arezzo	542
Parma	308	Venice	545
Pisa	324	Salerno	548
Sienna	324	Udine	558
Trieste	333	Varese	569
Florence	347	Chieti	573
Palermo	353	Catanzaro	584
Pavia	361	Pistoia	585
Messina	368	Trento	585
Catania	373	Lecce	587
Naples	387	Belluno	597
Perugia	398	Rovigo	598
Livorno	405	Taranto	600
Milan	406	Novara	601
Padua	409	Benevento	609
Reggio Calabria	410	Vicenza	609
Ferrara	417	Cosenza	611
Modena	424	Vercelli	619
Massa Carrara	425	Enna	627
Cagliari	437	Isernia	629
Pesaro	440	Sondrio	633
La Spezia	442	Treviso	637
Ancona	443	Como	638
Savona	443	Viterbo	640
Verona	446	Bolzano	645
Sassari	446	Foggia	648
Imperia	448	Teramo	664
Bari	467	Brescia	668
Lucca	480	Brindisi	676
Syracuse	481	Aosta	683
Gorizia	485	Bergamo	691
Grosseto	485	Caserta	692
Piacenza	490	Caltanissetta	693
Turin	500	Latina	693
Ravenna	502	Pordenone	693
Reggio Emilia	503	Trapani	693
Terni	504	Avellino	699
Mantua	511	Agrigento	709
Ragusa	515	Matera	718
L'Aquila	516	Frosinone	736
Forlì	519	Cuneo	749
Rieti	525	Asti	763
Cremona	526	Potenza	802
Alessandria	527	Nuoro	868
Pesaro	527	Oristano	1 031
Ascoli Piceno	533		
		TOTAL ITALY	451

G.5.2. Hospital beds

The hospital bed stock of Italy grew from 9.75 beds per 1 000 population in 1965 to 10.58 per 1 000 population in 1975. Over 80% of the bed stock is in public hospitals. The rest, less than 20% of the total, are in private institutions, many of which are run by religious orders. The average length of stay for acute care in hospitals in 1975 was 19 days. The average occupancy rate is around 80%.

Table 3

Distribution of hospital beds in 1974

Region	Beds per 1 000 population	
	General hospitals	All hospitals
Abruzzo	6.8	7.2
Basilicata	4.5	4.5
Calabria	3.5	3.9
Campania	2.9	4.0
Emilia-Romagna	7.4	8.7
Friuli-Venice Giulia	7.6	9.3
Lazio	3.8	4.7
Liguria	7.3	10.1
Lombardy	6.5	7.8
Marche	8.5	10.7
Molise	4.1	4.1
Piedmont	5.1	7.1
Puglia	6.0	6.8
Sardinia	4.2	5.3
Tuscany	7.4	8.6
Trentino-Alto Adige	6.5	7.4
Umbria	7.9	8.4
Valle d'Aosta	4.2	5.2
Veneto	9.8	10.8
Sicily	.	.

NB: The difference between general hospital beds and the total stock consists of sanatoria, psychiatric units and other specialized units.

Table 3 shows the geographical distribution of hospital beds in 1974. The worst-endowed area was Calabria and the best-endowed area was Veneto. The average length of stay in general hospitals varied from 10.4 to 15 days between the regions in 1974.

One of the primary objectives of the new Italian health-care system is to achieve a more equitable division of resources between the regions of the country. Whilst this objective has been articulated clearly, the means by which it is to be achieved are yet to be determined.

G.5.3. Distribution

Table 2 shows the geographical distribution (by province) of doctors in 1975. The best-endowed areas were Bologna and Rome. The worst endowed area was Oristano with four times as many inhabitants per doctor than Bologna.

G.5.4. Tariffs

G.5.4.1. Doctors

Prior to the recent reform of the Italian health-care system many doctors were paid on a fee per item of service basis. As a result of the recent reforms non-hospital doctors are paid on a capitation basis and the level of capitation fee is regulated by national conventions. Hospital doctors in public institutions are paid on a salary basis with those having part-time contracts supplementing their income with private practice fees.

G.5.4.2. Hospitals

The reform of the health-care system has also affected hospital finance. Private hospitals are financed on a daily-rate system as they were prior to the reform. However, public hospitals are given budgets and encouraged to operate within the budget constraints.

The hospital capital programme is regulated by three Rome Ministries (Public Work, Health and Finance). Most hospitals are built by the municipalities but no new construction is possible without central approval. The central government agencies hope to control new construction with a view to reducing regional disparities in hospital bed stocks. Hospital bed-stock guidelines have been evolved and the Regions are obliged to draft hospital plans on a quinquennial basis.

H. HEALTH CARE IN LUXEMBOURG

H.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

H.1.1. Evolution

The first national social security law to affect the finance and provision of health care in Luxembourg was enacted in 1901. This legislation was revised and expanded in 1951 (extension on white collar workers), 1954, 1957 (the self-employed) and 1962 (farmers). In 1974 the benefits of the different sickness insurance funds were harmonized and somewhat enlarged. This legislation covers cash and health care benefits.

H.1.2. Administrative Structure

H.1.2.1. Government

The health-care system of Luxembourg is in general under the supervision of the Ministry of Labour and Social Security.

H.1.2.2. Sickness Funds

Until September 1978 one national and two works sickness funds administered the contributions and benefits for wage earners. Six other funds administer the social security scheme for salaried employees. Since September 1978 the two works sickness funds for wage earners have been merged. Also two of the six funds for salaried employees have merged. Consequently there are only five funds for salaried employees and two for wage earners. The funds are managed by elected committees consisting of representatives of the insured and the employers. The funds operate under a central committee which has the power to regulate the funds and negotiate fees with health care providers. The committees consists of the presidents and vice-presidents of all the sickness funds in Luxembourg.

H.2. COVERAGE

All active workers, all those in receipt of a pension or an annuity, and all dependents of insured members are covered by compulsory health care insurance. This means that 99% of the population are covered by health care social insurance. The small number of people who are not covered by the legislation are eligible for benefits under the Social Aid programme if they pass means tests.

H.3. FINANCE

H.3.1. Income

H.3.1.1. Contribution from the insured

Before September 1978 the insured wage earners paid from 4 to 5.5% of their wages four times the national minimum wage rate (LFR 17 337 at 1 February 1978). Salaried employees paid from 2 to 2.6% of earnings to 2.75 times the national minimum wage rate. Pensioners paid 5% of their pension, up to four times (former wage earners) or 2.75 times (former salary earners) of the national minimum wage rate. The employer of wage earners and salaried staff paid the same amounts as their employees. Pension institutions also paid the same amount as their pensioner members. Since September 1978 wage earners and salary earners have to pay equal contributions of 1.95% of gross earnings up to four times the national minimum wage to finance in kind benefits (cash benefits are financed by an additional contribution of 1.8% of gross earnings up to the same ceiling for wage earners and 0.05% of gross earnings for salaried employees). The contribution rates of employers (pension funds) is the same as that of employees (pensioners). Three systems for mutual financial assistance have been established (September 1978). One of these is concerned with in kind benefits and the result is that any fund with a surplus pays it to funds in deficit.

H.3.1.2. Government contributions

The government pays 50% of the administrative costs of the sickness funds and pays subsidies particularly in the case of congenital malformations and costly illnesses. Also the government pays the costs of confinements and meets any deficits in pensioner contributions when such contributions do not cover the costs of health care.

H.3.1.3. Private finance

H.3.1.3.1. Private insurance

There is only one specialized health care insurance company in Luxembourg and its role is small and concerned with supplementing social insurance benefits. The expenditure of the private sector is equal to about 2% of the total cost of health care in the country.

H.3.1.3.2. Pricing

Since 1974 most health care benefits have been provided free of charge. The cost os the following items are financed in part by patients: the first home visit of a doctor (20% of the cost is paid by the patient); pharmaceuticals exept for in-patients (15% of the cost is paid by the patient); and false teeth 20% (but only if the patient has not had an annual dental inspection).

H.3.2. Expenditure

H.3.2.1. GNP

The percentage of GNP spent on health care was 2.1% in 1966, 2.5% in 1971 and 3.6% in 1976. These estimates take account of public expenditure only and ignore private outlays for which there are no expenditure estimates.

H.3.2.2. Expenditure characteristics

Aggregation of the expenditure flows resulting from social insurance, private insurance and private (non-insured) outlays is not attempted in this section. The objective is merely to give some indication of the expenditure pattern of the sickness funds and its rate of growth.

H.3.2.2.1. The expenditure pattern and its rate of growth

In 1975 the total expenditure level on health care was LFR 3 281.3 million of this total LFR 3 085.5 million was social insurance expenditure, LFR 58.1 million was voluntary insurance and LFR 137.7 million was social assistance. Health care expenditure of private households has risen by 85% from 1970 to 1975. Perhaps the most noteworthy fact about expenditure is the increase in the size of the goverment's involvement. In 1970 the government met 6.2% of social insurance expenditure. By 1975 the government was meeting 24.9% (over LFR 767 millions).

H.4 BENEFITS

Services are provided for the insured by doctors and hospitals which are covered by obligatory contracts with the funds. This care includes general and specialist care, hospitalization, laboratory services, maternity services, dental care, appliances, transport and pharmaceutical costs. The charges for health care are outlined in section H.3.1.3.2.

H.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. Although this is only a partial picture of the resource situation in Luxembourg, it highlights some important policy issues whose character is similar to those existing in other member countries in the EEC.

H.5.1. Doctors

In 1977 there were 133 general practitioners and 275 specialists (total 408) doctors in Luxembourg. The specialists generally work in private practices. There is no medical school in the country.

H.5.2. Hospital beds

In 1976 there was 30 hospitals in Luxembourg with 4 225 beds. Of these 30 hospitals, 17 were publicly owned and 13 were privately owned. The average length of stay for acute care in public hospitals in 1976 was 12 days. Since 1976 the government has controlled hospital expansion and a national plan is being formulated.

H.5.3. Tariffs

H.5.3.1. Doctors

Doctors are paid on a fee per item of service basis and the fees are negotiated between the central committee and the doctors' association (H.1.2.2.).

The exceptions are hospital doctors in the central hospital in Luxembourg who are employed directly by the hospital on a salary basis.

H.5.3.2. Hospitals

Hospital tariffs are paid at a uniform national rate by the sickness funds on a daily rate basis. These tariffs cover only the hotel costs of hospital care. The doctor is paid separately.

J. HEALTH CARE IN THE NETHERLANDS

J.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

J.1.1. Evolution

The first national regulation to affect the finance and provision of health care in the Netherlands was enacted in 1941. This regulation was most recently revised and expanded in 1964 (sickness fund system) and 1968 (AWBZ: heavy risks scheme).

J.1.2. Administrative Structure

J.1.2.1. Government

The administration of the social insurance health care system is decentralized and in the hands of sickness funds. The government's role in health care is limited to the regulation and approval of fees for doctors and hospitals, the planning of the system and the regulation and approval of the contribution rates to the funds. The minister determines the premium for the health insurance on the advice of the Sickness Funds Council. The Minister can veto all agreements which are made by the funds and approved by the Sickness Funds Council. However the Minister rarely uses this veto.

J.1.2.2. Sickness Funds

All sickness funds are supervised by the Sickness Funds Council. The Council is made up 36 members. (equal representation of the sickness funds organizations, health care providers, employees, employers and nominees of the Minister of Social Affairs and Public Health, together with four representatives appointed for AWBZ, and administer the General Fund into which compulsory sickness fund's insurance contributions are paid. The allocation criteria for this money is determined by the submission of bills by health care providers (i.e. it is an open-ended system), the Council also has an advisory role vis à vis the Minister.

At present the general scheme (1964) is administered by 71 sickness funds and these are federated into four national organizations. The federations combine to form the Joint Association of Sickness Funds e.g. to negotiate doctors' fees. The heavy risks social insurance programme (AWBZ 1968) is administered by the sickness funds, by private insurers and by public law bodies entrusted with the health care protection of civil servants. All three sets of bodies are supervised by the Sickness Funds Council.

J.1.2.3. Other

An independent Prevention Fund is concerned largely with research and shares out resources for various preventive medicine institutions. These monies are paid to it by the bodies administering the general scheme and the heavy risks scheme.

The Cross organizations provide nursing services and are important in organizing preventive care. There are three Cross organizations (Green, White-Yellow and Orange-Green). 11 out of 13 million Dutch citizens are covered by these organizations and they are funded out of subscriptions (28.4%) and government subsidies, (most, but not all of which comes from Central government).

General scheme benefits can be supplemented with voluntary additional cover from the sickness funds and with private insurance. The 30% of the population who are not covered by the general scheme buy private care. As a consequence the private health care insurance market is quite large. There are numerous private organizations offering private health care insurance cover and the premium income in 1978 was HFL 3 100 million.

J.2. COVERAGE

The general scheme offers a full coverage and membership is compulsory if the employee is earning less than HFL 36 200 (1978) per year (or HFL 118 per day). As a result of this the scheme covers 73% of the population (about 16% of this 73% are voluntary members who earn less than the earnings' ceiling but are not compelled to take cover and a further 20% are pensioners whose annual family income is less than HFL 20 409 and have elected to join the scheme).

The heavy risks programme offers a restricted list of benefits but covers 100% of the population.

J.3. FINANCE

J.3.1. Income

J.3.1.1. Contributions by the insured

The contributions to the general scheme finance benefits in kind. The contribution rate for compulsory members of this scheme (June 1978) was 8.2% of daily earnings up to a ceiling of HFL 118. Normally this contribution is divided equally between the employer and the employee. Voluntary members contribute amounts which vary from region to region. At present (1978) they range from HFL 91 to 115.5 per month for each insured person over the age of 16: (the average rate (1977) was HFL 107.15 per month).

The contribution rates of the elderly in this scheme vary with the family income of the contributor (at present the range for single people varies from HFL 25.10 per week to HFL 149.75 per month depending on income). The contribution rate for the heavy risks scheme is 2.86% of income up to the overall earnings ceiling of HFL 41 750. This premium is paid by the employee or resident.

J.3.1.2. Government contribution

Government contributions to the cost of health care in the Netherlands are substantial. Central government finance flows into the Cross societies and related organizations (in 1974 this amounted to 12.9% of expenditure). The provinces and the municipalities also make a substantial contribution in the form of subsidies contributing a further 2.1% of expenditure.

J.3.1.3. Private finance

J.3.1.3.1. Private insurance

As noted above (J.1.2.3.) private sector income is substantial.

J.3.1.3.2. Pricing

Most benefits under the general social insurance scheme are provided free of charge. There are exceptions e.g. 60% of the cost of providing false teeth has to be paid by the beneficiary. Also patients admitted to nursing homes and other facilities under AWBZ (heavy risks) programme have to contribute towards

the cost of care after they have stayed more than one year. These contributions are related to income. The income sources are summarized in Table 1.

Table 1

The finance of health care

	1963	1968	1970	1972	1974
	HFL million				
National Government	206.2	696.7	1 159.0	1 429.1	1 911.6
Provinces	14.8	13.8	17.4	14.6	17.4
Municipalities	198.2	146.3	191.9	220.5	287.3
Patients	1 770.8	3 865.9	5 770.7	8 770.3	12 321.6
Enterprises, et al.	41.6	86.2	116.0	156.5	233.4
TOTAL	2 231.6	4 808.9	7 255.0	10 591.0	14 771.3
	%				
National Government	9.2	14.5	16.0	13.5	12.9
Provinces	0.7	0.3	0.2	0.1	0.1
Municipalities	8.9	3.0	2.6	2.1	2.0
Patients	79.3	80.4	79.6	82.8	83.4
Enterprises, et al.	1.9	1.8	1.6	1.5	1.6
TOTAL	100	100	100	100	100

The national government finances preventive care and some services of the Cross Organization. The provinces are also subsidizing preventive care and some services of the cross organizations. The municipalities are financing municipal health services, cross organizations and sometimes the deficits of large general municipal hospitals. Under patients are included social and private insurance.

J.3.2. Expenditure

J.3.2.1. GNP

According to official estimates the percentage of GNP spent on health care was 5.3% in 1968, 6.8% in 1971 and 8.6% in 1976.

J.3.2.2. Expenditure characteristics

Aggregation and discussion of all the expenditure statistics is not attempted in this section. The objective is merely to give some indication of the expenditure pattern of the general scheme and its rate of growth.

J.3.2.2.1. The expenditure pattern

In 1968 the total expenditure on health care in 1968 was HFL 2 891 million. This expenditure level rose to HFL 6 470 million in 1972 and HFL 11 303 million in 1975. The expenditure categories and totals are set out in Table 2.

Table 2

Health care expenditure 1968-1975

(Mio HFL)

	1968	1970	1972	1973	1975 estimated
Community care	313	456	585	672	905
Mental ambulatory care	34	49	86	109	178
General practitioners	365	431	563	626	845
Dental care	406	503	613	729	1 033
Drugs and appliances	673	932	1 338	1 521	2 173
Paramedical care	62	76	111	130	180
SUBTOTAL	1 853	2 447	3 296	3 787	5 314
Care by specialists	588	764	1 136	1 401	2 061
General hospitals	1 557	2 210	3 260	3 781	5 518
Psychiatric hospitals	321	420	642	746	1 065
Nursing homes	260	471	940	1 187	1 759
Hospitals for the mentally retarded	165	300	492	619	900
SUBTOTAL	2 891	4 165	6 470	7 734	11 303

J.3.2.2.2. The growth of expenditure

The annual rate of growth of expenditure of the general scheme and the other component parts of the Dutch health-care system has been substantial as the GNP statistics indicate.

J.4 BENEFITS

The general scheme gives its members the right to short-term medical, pharmaceutical, dental, hospital and other types of care for the insured and his/her dependents. Every insured person is required to register with a physician approved by the Fund to which he belongs. Most general practitioners work in solo practice although group practice and health centres are increasing in number and are favoured by the government. The average doctor list size is 2 633 of whom 1 900 are insured in the general scheme. The services of the doctor are provided free of charge and the doctor is paid directly by the sickness funds on a capitation basis.

Specialist care is provided only after authorization by the patient's general practitioner. Specialist care may be provided in hospital in an out-patient clinic or in the specialist's premises. Specialist care in the home is rare.

Dental care is obtained free of charge for children under four. Other persons can buy a treatment certificate at a low price, which is valid for six months and entitles the holder to free (e.g. fillings and extractions) and subsidizes (e.g. the provision of false teeth) treatment.

Pharmaceutical products are dispensed by chemists in urban areas and by doctors in some rural areas. All drugs and dressings are provided free of charge.

Hospital treatment for periods of up to 365 days is provided free of charge for all general scheme fund members.

Those not covered by the general scheme pay for all the health care benefits listed above out of their own resources or by private insurance. However all the population is insured against the cost of treatment in nursing homes and hospital care after the 365th day. Under the heavy risks legislation nursing home care for the elderly and the chronic sick for all the population is covered from the first day as is care in institutions for the physically and mentally handicapped.

J.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. Although this is only a partial picture of resource situation, the statistics provided highlight some important policy issues which are common to all members of the EEC.

J.5.1. Doctors

The total number of general practitioners in the Netherlands in 1976 was 4 937. There were 7 223 specialist doctors. A further 1 158 worked in community medicine. A residual category of 8 574 had roles which are not defined in the official statistics. The total number of doctors in 1976 was 21 892 i.e. 159 per 100 000 population. The categories and geographical location of doctors is set out in Table 3. The rate of medical school output was 1 357 in 1975/76 and went down to 1 292 in 1976/77. Since 1971 it has been regulated by the government (numerus clausus).

J.5.2. Hospital beds

Only a few hospitals are publicly owned, all others being non-profit making. Public hospitals tend to be larger. In 1976 there were 166 731 hospital beds in the Netherlands, of which 74 645 were in acute care, 39 910 were nursing home beds, 26 268 were psychiatric beds, and 15 908 were beds for the mentally handicapped. Details of this stock are set out in Table 4.

Since 1971 all capital expenditure on hospitals has been subject to authorization by the Ministry. The 1971 legislation required all provinces to produce hospital plans which after discussion are used by the Minister to produce the national plan. The government plan to reduce the number of acute hospital beds from 5.4 per 1 000 (1978) to 5 per 1 000 in 1980 and to 4 per 1 000 later in 1980s.

This plan inevitably involved hospital closures and provoked political opposition. The government controls capital expenditure by a licensing system. The number of licenses to build hospitals has been declining (the 1975 level was half that of 1974) and in 1978 a monetary ceiling was set by the Government for hospital building.

J.5.3. Distribution

Tables 3 and 4 showed the regional distribution of hospital beds and doctors in the Netherlands. From these tables it can be seen that the distribution of hospital beds varies quite substantially. Similarly the number of doctors between the different areas of the Netherlands varies quite substantially.

Table 3

The doctor stock in 1976

Province	General practitioners		Specialists		Public health		Other doctors		Total	
	Total	Per 100 000 inhabitants	Total	Per 100 000 inhabitants	Total	Per 100 000 inhabitants	Total	Per 100 000 inhabitants	Total	Per 100 000 inhabitants
Groningen	204	38	330	61	40	7	556	103	1 130	209
Friesland	228	41	179	32	35	6	187	33	629	112
Drenthe	162	40	229	56	33	8	240	59	664	163
Overijssel	332	33	422	41	76	7	405	40	1 235	121
Gelderland	584	36	815	50	140	9	1 047	64	2 586	158
Utrecht	348	40	726	84	106	12	907	104	2 087	240
North-Holland	893	39	1 526	68	214	9	1 941	83	4 583	200
South-Holland	1 052	35	1 651	54	282	9	2 151	71	5 136	169
Zeeland	126	38	103	31	21	6	85	26	335	101
North-Brabant	631	32	778	40	138	7	714	36	2 261	115
Limburg	377	36	428	41	73	7	368	35	1 246	118
TOTAL NETHERLANDS	4 937	36	7 223	53	1 158	8	8 574	62	21 892	159

See 'Compendium Gezondheidsstatistieken 1974', Centraal Bureau voor de Statistiek.
Source: Geneeskundig Hoofdinspecteur van de Volksgezondheid.
In: 'Vademecum Gezondheidsstatistiek Nederland 1977' Centraal Bureau voor de Statistiek.

Table 4

The hospital stock

Number of hospitals and beds per province

Province	Hospitals	Beds	
		Total	Per 1 000 inhabitants
Groningen	8	3 000	5.58
Friesland	9	2 497	4.48
Drenthe	5	1 493	3.70
Overijssel	16	5 223	5.32
Gelderland	36	8 449	5.18
Utrecht	20	5 956	6.90
North-Holland	58	14 859	6.49
South-Holland	51	16 210	5.34
Zeeland	10	1 716	5.21
North-Brabant	27	9 402	4.81
Limburg	15	5 840	5.57
NETHERLANDS	255	74 645	5.46

Psychiatric hospitals

Province	Hospitals	Beds	
		Total	Per 1 000 inhabitants
Groningen Friesland	4	1 369	1.25
Drenthe	5	2 085	5.17
Overijssel	3	2 085	1.03
Gelderland	13	3 143	1.91
Utrecht	7	2 196	2.55
North-Holland	8	3 566	1.56
South-Holland	16	6 058	2.00
Zeeland	-	-	-
North-Brabant	12	4 561	2.34
Limburg	4	2 277	2.17
NETHERLANDS	72	26 268	1.92

Hospital for the mentally retarded

Region	Hospitals	Beds	
		Total	Per 1 000 inhabitants
North-Netherlands	7	1 797	1.20
East-Netherlands	37	6 777	2.59
West-Netherlands	47	8 222	1.33
South-West-Netherlands	5	718	2.18
South-Netherlands	129	25 908	1.90

Nursing homes

Provinces	Nursing homes	Beds	
		Total	Per 1 000 inhabitants
Groningen	12	1 485	2.76
Friesland	16	2 137	3.84
Drenthe	5	648	1.61
Overijssel	19	2 270	2.31
Gelderland	35	4 385	2.69
Utrecht	21	2 361	2.74
North-Holland	53	7 100	3.10
South-Holland	76	10 471	3.45
Zeeland	7	1 093	3.32
North-Brabant	38	4 886	2.50
Limburg	16	2 984	2.85
TOTAL NETHERLANDS	298	39 910	2.92

J.5.4. Tariffs

J.5.4.1. Doctors

Doctors involved in primary and secondary care are paid on a capitation basis. The capitation fees are negotiated by the doctors and the Joint Association of Sickness Fund Organizations. The basis net fee for a general practitioner in 1976 was HFL 43.18.

J.5.4.2. Hospitals

The hospitals are paid by the insurers on a daily rate system. The Central Foundation for Hospital Tariffs, under government pressure has exerted tight control on the growth of these rates in the last few years. The government is seeking legislation to acquire greater control of hospital charges for general scheme members and those who are privately insured.

K. HEALTH CARE IN THE UNITED KINGDOM

K.1. EVOLUTION AND ADMINISTRATIVE STRUCTURE

K.1.1. Evolution

The first national social security law to affect the finance and provision of health care in the United Kingdom was enacted in 1911. The National Health Service was established in 1948 by legislation passed in 1946.

K.1.2. Administrative structure

K.1.2.1. Government

At the national level the Secretary of State for Social Services is responsible for the administration of the National Health Service in England. In Scotland and Wales the Secretary of State for Scotland and Wales respectively are responsible for the NHS in their parts of the United Kingdom. In Northern Ireland the Health and Social Services Board is the responsible body. The Secretaries of State set general guidelines concerning the provision of health care and controls the allocation of funds in England, Scotland and Wales. The structures in England and Scotland are separate, but similar, and in the following the English system is discussed. The health service is administered at the regional level by 14 Regional Health Authorities (RHA) in England. Each RHA has at least one medical school in its area, and the RHA's role consists chiefly of NHS planning i.e. translating national priorities into a set of regional objectives and plans. In carrying out this role they have to coordinate their activities with their constituent Area Health Authorities (AHA) and allocate finance received from the DHSS to each of the AHA. The most important authorities in the administrative structure of the NHS are the Area Health Authorities, who have the statutory responsibility for running the health services in each of the 90 English areas. Except in London, the boundaries of the AHAs are the same as those of the local government units (the Counties and Metropolitan Districts). The AHA's are responsible to the RHAs for the running of the area's health care services, though some individual officers of the Area Team

of Officers (ATO) may be accountable individually also. There are Joint Consultative Committees with Joint-Care Planning Teams responsible at this level for the coordination of local government (who provide personal social services) and AHA activities.

The smallest administrative units are the Districts serving, on average, a population of 250 000. These units are responsible for delivering the full range of health services in the district and have a general hospital's specialist services. District boundaries are based on 'natural' catchment areas, and have four key organizations: the District Management Teams (DMTs) the District Medical Committees (DMCs), the Health Care Planning Teams (HCPTs), and the Community Health Councils (CHCs). The DMT manages and coordinates the operational part of their local health care unit and is responsible for formulating future plans. The DMC is made up of hospital and non-hospital doctors and dentists who represent the medical and dental profession at the local level. The HCPTs are responsible for the development of plans for the integrated care of particular client groups (e.g. the elderly). The CHCs are not formally a part of the management structure, but are generally lay members nominated partly by local interest groups, partly by the local RHA, and partly by the local authority. These bodies have a 'watchdog' role but their powers are limited, and their levels of activity vary considerably from one locality to another.

K.1.2.2. Sickness funds

There are no sickness funds involved in the finance and provision of health-care social insurance in the United Kingdom.

K.1.2.3. Other

Private health-care insurance covers about two million people and the market is dominated by the British United Provident Association, the Private Patients' Plan, and the Western Provident Association (non-profit making bodies). Several other bodies offer a variety of insurance policies but, although the market has become more competitive recently (as evidenced by new types of policies), the total market size is relatively static.

K.2. COVERAGE

Since 1948 the National Health Service has been available for use by all residents in the UK.

K.3. FINANCE

K.3.1. Income

As can be seen from Table 1 the chief source of finance for the National Health Service is general taxation (the Consolidated Fund). Social insurance contributions are very small and generate only UKL 461 million in income. Charges to patients produce UKL 110 million (of which, in 1975/76, UKL 37 million (33.6%) was derived from dental charges, UKL 27 million (24.5%) was derived from pharmaceutical pricing, UKL 25 million (22.7%) from hospital pricing, UKL 20 million (18.1%) from opthalmic charges, and UKL 1 million from welfare food pricing). These characteristics of the income of the NHS have changed little in the last five years.

Table 1

National Health Service Finance 1975/76 (Great Britain)

	Mio UKL	%
Consolidated Fund	4 834	89.18
NHS contributions	461	8.50
Charges to recipients	110	2.02
Miscellaneous	15	0.27
TOTAL	5 420	100

Source: Department of Health and Social Security (1977); Health and Personal Social Service Statistics, HMSO Table 2.2, p. 19.

K.3.2. Expenditure

K.3.2.1. GNP

The percentage of GNP spent on health care was 4.27% in 1966, 4.81% in 1971, and 5.40% in 1975.

K.3.2.2. Expenditure characteristics

About 90% of NHS expenditure is budget limited. A cash allocation is made out of the national budget and this includes an allowance for expected increases in costs during the year and a small allowance for real growth. These cash limits must not

be exceeded. If costs rise more than expected, the real growth of the service may be curtailed unless greater efficiency in the use of resources can be achieved. The actual real growth (capital and current) in Great Britain was 3.8% in 1973/74, 0.9% in 1974/75, 2.9% in 1975/76 and 1.1% in 1976/77.

The expenditure characteristics of the NHS are set out in Table 2. Current expenditure by the AHAs, largely on hospital care, is the largest expenditure item in this list.

The general medical, dental and opthalmic items finance care in the community (i.e. outside the hospital). The Pharmaceutical item is primarily controlled by price and profit regulation of the industry.

Table 2

National Health Service expenditure 1975/76 (Great Britain)

	Mio UKL	%
Central administration	40	0.73
Health Authorities [1]		
(i) current	3 758	69.33
(ii) capital	395	7.28
General medical	333	6.14
Pharmaceutical	467	8.61
General dental	231	4.26
General opthalmic	72	1.32
Welfare foods	15	0.27
Other	109	2.01
TOTAL	5 420	100

1 This includes the administration of the Family Practitioner Service and the costs of hospital care. The costs of care provided by doctors, pharmacists, dentists and opticians in the family practioner services are shown in the general medical, pharmaceutical, dental and opthalmic categories.

Source: op. cit., Table 2.1., p. 18.

K.4. BENEFIT

General practitioners and pharmacists outside hospitals work under contract with the local Family Practitioner Committee of

the AHA. The general practitioner is paid by a hybrid payment system: on average about 55% of the general practitioner's income is generated by capitation fees, the rest is derived from payments for items of service (e.g. vaccination and maternity care), payments related to age (seniority payments), and in some cases payments related to location (designated area allowances). The pharmacist is paid for each item made up for patients. Each patient registers with a general practitioner and most people do not change their registration unless they move to a different geographical area. The patient has the right to choose and change general practitioner freely. Most general practitioners now operate in group practices and the number of health centres has grown rapidly in the last 10 years, as a result of government encouragement. Health centres often provide medical care (provided by doctors and nurses) and dental care. The patient's first point of contact with the health-care system is the general practitioner (GP). The GP can refer the patient to a specialist who is hospital based. Out-patient and in-patient care in hospitals is free of charge. Access to elective care (cold surgery) is rationed by time (waiting lists), the acutely ill gain access to care on demand. A patient's participation in the costs of care is limited. A charge of UKL 0.20 per item is made for pharmaceutical products and there are charges also for dental care, opthalmic care, and some appliances. All these charges are levied on the more affluent client groups with only the poor i.e. those in receipt of Supplementary Benefit (public assistance), the aged, the chronic sick, expectant mothers and children being exempted from charging generally. No charges are made for general practitioner visits or for hospitalization although some groups favour the use of such policies.

K.5. RESOURCES

This section is concerned with the quantity, price and distribution of doctors and hospital beds. This is only a partial picture of the resource situation but the statistics highlight some important policy issues whose character is similar throughout the nine countries of the EEC.

K.5.1. Doctors

Table 3 shows the distribution of doctors in England, Wales and Scotland.

In 1975 the doctor stock in Great Britain (England, Scotland and Wales) was 118.6 per 100 000 population. Since 1965 new medical schools have been opened and the output of medical students has been increased. By the early 1980s the output of the schools is planned to be just over 4 000 per year.

Table 3

Doctor Stock per 100 000 population. Great Britain 1975

Region	Doctors per 100 000 population
Northern	110.5
Yorkshire	103.5
Trent	93.5
East Anglia	105.8
North-west Thames	146.5
North-east Thames	138.6
South-east Thames	127.1
South-west Thames	121.8
Wessex	107.5
Oxford	112.2
South Western	107.2
West Midlands	103.9
Mersey	111.9
North Western	111.6
Wales	114.1
Scotland	160.3
Great Britain	118.6

Table 4

Distribution of hospital bed stock in England in 1976

Region	Allocated beds per 1 000 population
Northern	8.7
Yorkshire	9.1
Trent	7.2
East Anglia	7.6
North-west Thames	8.9
North-east Thames	8.6
South-east Thames	8.7
South-west Thames	10.0
Wessex	7.6
Oxford	6.7
South Western	8.2
West Midlands	7.4
Mersey	9.5
North Western	8.0
TOTAL ENGLAND	8.4

Source: op. cit., Table 4.10, p. 83.

K.5.2. Hospital beds

Table 4 shows the hospital bed stock by region in England in 1976, the least well-endowed regions, Oxford and Trent, have bed stock allocations considerably less than those of the best-endowed region, south-west Thames.

The average length of stay in acute specialities in England declined from 13 days in 1966 to 9.8 days in 1976.

K.5.3. Distribution

As can be seen from Table 3 and 4 the Geographical distribution of doctors and hospital beds in the NHS is unequal. The doctor stock per 100 000 population varies from a low of 93.5 in Trent to a high of 160.3 in Scotland i.e. the Scottish endowment is over 70% higher than that of the Trent region in England. The distribution of hospital beds is also unequal with, in England, the Thames (London) areas being better endowed than northern areas such as Trent. One of the main arguments put forward in favour of a National Health Service prior to 1948 was that it would reduce geographical inequalities in the distribution of resources. Thirty years later significant inequalities remain but of late much more clearly articulated policies have been articulated to rectify these problems. New budget allocation formulae (in England RAWP and in Scotland SHARE) have been devised which, if implemented, will reduce geographical inequalities in Northern England and Northern Scotland by controlling the flow of resources to constituent regions during the next ten years. These budget formulae, which have been used since 1976/77, together with DHSS control of the capital programme, may result in the mitigation of regional inequalities in the distribution of health care facilities in England and Scotland if the political costs of hospital closures and the abolition of doctors' posts can be accepted.

K.5.4. Tariffs

K.5.4.1. Doctors

General practitioners are paid largely by capitation fees but also with fees per item of service and other allowances. Hospital doctors receive a salary. Junior hospital doctors often get substantial overtime payments which can result in their renumeration exceeding that of their superiors, the consultants. This outcome is the result of more militant bargaining by the junior hospital doctors, but may be reversed if recent Review Body recommendations are implemented. Consultants are eligible to receive distinction award supplements to their salary (about

1 in 3 receive such payments, a small number of which can double the consultant's remuneration). All salary proposals emanate from the independent Review Body on Doctors and Dentists' Renumeration.

K.5.4.2. Hospitals

Hospitals are financed out of NHS revenues by the AHAs who receive their monies from the RHAs and the DHSS.

Part II

THE COST OF HEALTH CARE

A. INTRODUCTION

Concern about the rising cost of health care is mainly focussed on those costs which fall on the public sector and are financed by taxation or social security contributions or some mixture of the two. It is part of the wider problem of the growing cost of social security and of the social budget generally. But there is also growing criticism that the vast increase in real expenditure on health services throughout the Community over the past few decades has not lead to anything like commensurate improvements in health status as indicated by mortality rates.

When national economies were growing rapidly it caused less concern for publicly financed social expenditure to rise as a proportion of gross national product as there was still also room for a substantial growth of real levels of private expenditure. In the last few years the lower rates of economic growth have made it much less acceptable for the proportion of publicly financed social expenditure in the national product to continue to increase. Pressure to increase real private consumption or to increase it at a faster rate is believed to be one of the factors generating inflation in some countries. There is always a tendency for the people of the Community to have aspirations which are incompatible - for example, to wish to retain more of their earnings to spend on themselves, to have a shorter working week, while at the same time to demand improvements in social security whether by higher levels of benefits, pensions available at an earlier age or improved health services. Nevertheless, over the past few years the feeling has grown stronger in several countries that the level of taxation and social security contributions has become too high and ought to be reduced. One response to the growing trend of opinion has been to shift more of the cost of health services from the public sector to the private sector by charges for health care or reduction in the percentage of reimbursement even where the total cost is unlikely to be greatly changed.

Independent of these concerns has been worry about the underlying problem of the low rate of economic growth, and the much higher level of unemployment in the Community which on present trends appears likely to persist well into the 1980s. While there is potential for alleviating the unemployment by work-sharing, this involves an acceptance that the problem cannot be wholly resolved by measures to generate a higher rate of economic growth. There is therefore a search throughout the Community for labour-

intensive activities which be expanded. The health care sector is undoubtedly an area in which more jobs could readily be created on a considerable scale if the money were found to pay for the services. Moreover the health equipment industry is clearly a growth industry throughout the world with major export potential. The growth of the Community's health services would provide an expanded home market which could be a valuable base for a higher level of exports. Thus the tendency to restrain the growth of health services has been at the expense of higher levels of employment and has probably harmed the prospects of an industry with potentiality for higher growth and enlarged exports.

All these conflicting considerations can only be resolved through the political process. In this part of the report the trends in health service expenditure are examined, the reasons for rising costs are analysed and the actions being taken or under consideration in the different countries are described. It is not intended to leave the impression that it is necessarily right for the cost of health services to be cut back in the long run. While savings could undoubtedly be made if health services were made more efficient, health services which are effective in preventing ill health, curing illness and provide care for those whose health cannot be improved are of undoubted social value. It is the task of Governments to assess this value and compare it with the unpopularity of high levels of taxation and social security contributions and to examine the potentiality of the health care sector as against other sectors increating new jobs.

B. TRENDS IN EXPENDITURE ON HEALTH SERVICES (1966 - 1975/76)

The definition of health services is not uniform throughout the Community. There are, for example, intrinsic problems in drawing a clear line between hospitals and other types of institutions which provide care for persons who are frail, senile, chronically disabled, of limited intelligence or who exhibit anti-social or criminal behaviour Staff performing particular functions may be deployed inside or outside what are classified as health services. There is, moreover, no uniform definition of a drug, medical appliance or nursing aid.

A second series of problems arises when government departments provide health services for certain categories of persons (such as members of the armed forces and prisoners). Such health services may be classified as part of the cost of prisons or of the armed forces. Similarly some health functions may be performed by a variety of other agencies e.g. veterinary services to safeguard human health.

The cost of health services in the different countries cannot be obtained in a complete or comparable form by assembling the relevant items in the national accounts. This is partly because all expenditure on health services cannot be identified in the accounts and partly because the definitions applying to those items which can be identified leave room for a variety of different interpretations.

The estimates given here for the cost of health services are based on data which have already been collected in each country. It would have been a major task to have attempted to collect new data on a comparable basis for all countries in the Community. The data was assembled as part of the study of pharmaceutical consumption. The aim was to obtain estimates of private and public expenditure on health services. The estimates aimed to cover only current expenditure as it was known that data on capital expenditure was not available for several countries.

The estimates of health service expenditure vary in completeness. While comprehensive information is periodically collected for some countries in the Community conforming to the definitions used in that country, the information for other countries is less complete or could only be estimated with a considerable margin of error.

Table 1

Estimates of the current[1] cost of health services (including tax) as a percentage of GNP - EEC 1966-76

%

Year	Belgium	Denmark	FR of Germany	Ireland	France	Italy	Luxembourg Health Insurance only	Netherlands	United Kingdom England & Wales only
1966	-	3.8	4.8	3.6	5.1	3.2	(2.1)	-	4.3
1967	-	4.0	5.2	3.7	5.3	3.4	(2.3)	-	4.4
1968	-	4.3	5.3	3.7	5.1	3.4	(2.4)	(5.3)	4.4
1969	-	4.4	5.2	3.8	5.4	3.4	(2.3)	-	4.6
1970	-	4.6	5.2	4.5	5.5	3.9	(2.4)	6.3	4.6
1971	-	4.8	5.7	4.5	5.6	4.3	(2.5)	(6.8)	4.6
1972	-	5.0	6.1	4.7	5.7	4.7	(2.5)	7.2	4.5
1973	4.5	5.0	6.4	5.2	5.8	4.7	(2.4)	(7.4)	4.4
1974	5.0	5.5	7.1	-	5.9	5.7	(2.3)	7.9	4.9
1975	6.2	6.1	8.0	6.6	6.7	5.2	(3.5)	(8.4)	5.4
1976	-	-	8.0	6.1	-	4.9	(3.6)	(8.6)	-

1 Includes capital cost of hospitals in the case of Belgium.

Belgium: The estimates were made by the Department of Public Health and cover only the years 1973 to 1975 inclusive. They include capital investment in hospitals, the depreciation of hospital buildings and part of the cost of administration. Training, research, public preventive services and part of the cost of provision for the mentally retarded are excluded.

Denmark: The figures cover the expenses of sickness insurance, expenditure on doctors' bills, midwifery and hospitals of every kind except some small institutions for the mentally retarded (amounting to a cost of about DKR 300 million in 1974/75).

Ireland: The figures are estimates for the running costs of all statutory health services. They include the cost of administration, training, research and public health services. The depreciation of buildings is excluded.

France: The figures are for the total running costs of medical care services. They exclude the cost of administration of the central government and of health insurance, training, research, public health services and all capital investment. The depreciation of the buildings is included in hospital running costs.

FR of Germany: The figures are based on semi-official but imperfect estimates for running costs for the years 1968 and 1972 exclude the cost of research, training and depreciation. Also psychiatric care is not fully included in the estimates. The figures for the other years have been estimated on the basis of trends in the expenditure on the compulsory and private health insurance schemes. The resultant figures provide only a broad indication of trends - particularly because of the imperfection in the data for the two base years.

Italy: The figures included are taken from the General Survey of the national economic situation 1966-75. The figures for 1976 are derived from the accounts of the agencies responsible for providing services. They cover treatment costs and exclude expenditure on administration, research, training and depreciation. They are mainly derived from the health insurance statistics but include the central government contribution towards the running costs of hospitals. Health care expenditure by local agencies is excluded but it is verry small in relation to the total. The cost of treatment for industrial accident and occupational diseases are included but not the cost of cash benefits. In the case of medicines obtained without prescription only registered medical products are included.

Luxembourg: The figures cover total expenditure on health services by the compulsory health insurance scheme which covers virtually the whole of the population but not the share of the cost falling on patients, which is unknown. Administration costs, research, training and depreciation are excluded.

Netherlands: The figures are those compiled by the central statistical office which has undertaken extensive work over the years. In the early years the survey was undertaken every five years, as from 1968 every two years and from 1976 every year. The figures include administration, depreciation and such research and training as is done as part of the ordinary work of the hospital-and other health care institutions-but excludes the cost of the parmaceuticals which were not prescribed by a doctor. The figures in brackets are estimates or in the case of the figure for 1968 not strictly comparable with the later figures.

United Kingdom: The data are for England and Wales only (Scotland and Northern Ireland are excluded). The figures cover the whole cost of the National Health Service including administration, training and research and charges paid by patients. No depreciation is included. There are slight imperfections in the figures caused by the transfer of some health services to the welfare services in 1970. Moreover a small amount of capital expenditure incurred by local authorities is included in the years 1970 to 1973. This is excluded from 1974 onwards. To these figures for the National Health Service have been added the cost of private medical care purchased outside the National Health Service included the cost of pharmaceuticals purchased without a prescription. The figures are for financial years (e.g. April 1966 to end March 1967 for 1966).

The figures in Table 1 must be interpreted with great caution. Notes on the coverage and sources of the figures are given beneath the table. There are in addition the major conceptual problems described earlier. Important identified reasons for non-comparability are the following:

1. The figures for Belgium include some capital costs and the figures for the other countries exclude them.

2. The figures for Luxembourg are for health insurance services only.

3. The cost of the depreciation of hospital buildings is included in the figures for France, the Netherlands and partly in those for Belgium, but not in those for the other countries.

4. The figures for Germany are based on imperfect semi-official estimates for the two years 1968 and 1972. The figures for the other years are estimated on the basis of trends in the expenditure of the health insurance schemes.

5. The figures for the Netherlands exclude non-prescription drugs and those for Italy include only registered medical products obtained without prescription.

6. The figures for Ireland cover only the net cost of statutory services which have almost certainly grown faster than statutory and private services combined because of the transfer from private to statutory services during this period.

The estimates of expenditure on health services including taxation are shown in Table 1 as a proportion of gross national product. In all countries of the Community, the cost of health services has been rising faster than national product. The most rapid rate of growth in relation to national product has been in Ireland where the proportion nearly doubled between 1966 and 1975 from 3.6% to 7%. The slowest rates of growth were in Denmark and the United Kingdom (England and Wales). The highest percentage shown in the table is for the Netherlands which had reached 8.6% by 1976 and the estimate of cost excludes non-prescription drugs. Next largest was Germany at 8.0% in 1976 and France at 6.7% in 1975. Ireland was just below France at 6.6% in that year.

The effect of the fall or lower rate of growth of product from 1974 onwards is clearly apparent. (See Table 2). Between 1973 and 1975, the addition to the proportion of gross national product spent on health services was 1.7% in Belgium, 1.6% in Germany, 1.6% in Ireland, nearly 1% in France, 1.1% in Luxembourg (health insurance only) 0.5% in Italy and 1% in the United Kingdom (England and Wales). In the latter a major reason for this increase was the realignment of pay in the public sector following pay restraint policies which had had the effect of discriminating against the public sector.

Table 2

Growth of gross domestic product - EEC 1966 - 1976 (at prices)

(1 000 million national currency)

Year	Belgium BFR	Denmark DKR	FR of Germany DM	Ireland[1] IRL	France FF	Italy LIT	Luxembourg LFR	Nether-lands HFL	United Kingdom UKL
1966	1028.02	96.780	559.75	1.3283	631.05	45.896	45.997	89.316	46.000
1967	1067.86	100.884	558.84	1.3956	660.92	49.117	46.089	94.080	47.209
1968	1112.73	104.735	593.97	1.4959	689.25	52.221	47.979	100.400	48.821
1969	1186.62	113.717	640.46	1.5792	738.82	55.182	51.961	107.210	49.489
1970	1262.11	116.801	678.75	1.6255	782.56	57.937	53.156	114.573	50.724
1971	1311.92	120.966	700.68	1.6911	824.13	58.836	54.485	119.590	52.127
1972	1382.64	126.212	726.28	1.7828	874.58	60.689	56.882	124.280	53.395
1973	1469.62	129.764	761.84	1.8611	922.06	64.905	60.921	131.610	56.907
1974	1527.22	129.981	765.95	1.8867	947.52	67.459	62.992	137.140	56.541
1975	1494.43	128.549	746.15	1.8920	953.88	65.086	58.142	135.530	55.642
1976	1539.26	135.402	787.76	1.9530	1005.37	68.752	59.712	141.800	57.092
				Index (1966 = 100)					
1966	100	100	100	100	100	100	100	100	100
1967	103.9	104.2	99.8	105.1	104.7	107.0	100.2	105.3	102.6
1968	108.2	108.2	106.1	112.6	109.2	113.8	104.3	112.4	106.1
1969	115.4	117.5	114.4	118.9	117.1	120.2	113.0	120.0	107.6
1970	122.8	120.7	121.3	122.4	124.0	126.3	115.6	128.3	110.3
1971	127.6	125.0	125.2	127.3	130.6	128.2	118.5	133.9	113.3
1972	134.5	130.4	129.8	134.2	138.6	132.2	123.7	139.1	116.1
1973	143.0	134.1	136.1	140.1	146.1	141.4	132.4	147.4	123.7
1974	148.6	134.3	136.8	142.0	150.1	147.0	136.9	153.5	122.9
1975	145.4	132.8	133.3	142.4	151.2	141.8	126.4	151.7	121.0
1976	149.7	139.9	140.7	147.0	159.3	149.8	129.8	158.8	124.1

[1] 1966 - 1969 deflated with GNP - deflator.

Table 3

Estimate of growth of the current[1] cost of health services (including tax) per head of total population at constant prices[2] EEC 1966-76 (1966 = 100)

Year	Belgium	Denmark	FR of Germany	Ireland	France	Italy	Luxembourg (Health insurance only)	Nether-lands	United Kingdom (England & Wales only)
1966		100	100	100	100	100	100		100
1967		102.9	107.5	106.2	107.2	113.2	106.9		106.4
1968		112.5	119.8	115.2	108.6	123.3	116.4		107.3
1969		131.0	129.2	127.0	122.6	134.7	125.8		111.1
1970		140.9	139.5	149.8	131.1	159.6	150.8	100	116.8
1971		151.8	161.3	155.6	140.5	184.2	146.6	(111.2)	118.3
1972		166.0	177.6	177.9	149.4	204.3	153.1	122.7	124.1
1973	(100)	171.2	195.6	206.1	159.1	220.0	166.5	(132.6)	128.2
1974	(114.7)	185.6	216.6	-	162.7	264.4	173.1	141.9	143.8
1975	(139.7)		239.2	243.7	179.6	233.5	228.7	(152.1)	157.0
1976	-		252.2	233.7	-	235.1	226.4	(158.3)	-

[1] Includes capital cost of health services in the case of Belgium.
[2] Using retail price index.

The estimates of total expenditure on health services are shown in Table 3 per head of population in constant prices. The retail price index of each country is used to make the calculation in view of the absence in most countries of the Community of a special price index for health service costs. The use of such a price index means that the estimates of health service expenditure at constant prices will combine both changes in volume supplied (for example more bed days) and any changes in the price of health services (for example cost per bed day) in relation to retail prices. In most countries retail prices probably rose less than health service prices over the period, so that the rise in the volume of health services will be lower than the indices shown in Table 3.

The calculation suggests that among countries with figures covering the period 1966 to 1975, the relative rate of growth per head in real terms has been fastest in Ireland where the cost has grown by nearly two and a half times. The rise in Germany over this period was not far below that in Ireland and greater in the period up to 1976. In Italy and Luxembourg (health insurance only) the rise was around two and a quarter. The lowest rate of growth was in the United Kingdom (England and Wales) where the cost of health services per head only increased by a little over a half.

The figures presented in Tables 1 and 2 cover the period up to 1975 or 1976. In Germany, France and the Netherlands, the rate of increase of health service expenditure is believed to have been at a slower rate over the period 1975 to 1978 than in the earlier period shown in the tables. Public discussion of the need to moderate the growth in cost is believed to have led doctors to become more restrictive in what they have authorized for their patients and made hospitals more cost conscious. Moreover tighter control has been exercized on the growth of hospital costs in these countries and also in Belgium. In Ireland and the United Kingdom, there have been deliberate restrictions on the rate of growth of public expenditure which have led to a lower rate of growth of publicly financed health services. When figures for the cost of health services become available for the period up to 1978, it will be interesting to see the effects of the measures taken to control costs over the past few years which are described later in this report.

It is no possible to divide the total cost of health services into sectors of expenditure on a comparable basis for the different countries of the Community because of differences in the organization and financing of services. A major difference is in what is counted as part of hospital costs. In some countries such as Denmark, Ireland or the United Kingdom, virtually all the specialist services are provided at hospitals for out-patients as well as in-patients. In other countries a high proportion of specialist services are provided separately from hospitals.

Secondly, the work that doctors do at hospitals is paid for through the hospital budget in some countries and is separately paid for in whole or part in other countries. The data for all countries in the Community (except Ireland) indicates that the growth of expenditure on the hospital specialist and diagnostic services over the period 1966 to 1975 has been the largest single reason for rising costs. For example, in the Netherlands hospital and specialist services rose from 55% of the cost of health services in 1968 to 63% in 1975. Pharmaceutical consumption has taken a declining share of health services costs in each of these eight countries. The experience of Ireland has been different owing to the introduction of the general medical services scheme from 1971 onwards. While hospital costs have been subject to tight budget control, the general practitioner service has become an increasing share of the cost. This has been partly due to an extension of the coverage of the scheme from about 850 000 persons in 1970 to nearly 1.2 million persons in 1976. It has also been partly due to the introcution from 1972 of a payment system for general practitioners based on each consultation from 1972.

C. REASONS FOR THE INCREASING COST

In the market for health care supply and demand are not simply related by price. Between the patient and the bulk of health resources is interposed the doctor (or dentist). It is the doctor or dentist, not the patient, who decides what health care will be supplied. The doctor whom the patient first consults acts as authorizer of the use of health resources and also as provider of health services to an extent which varies among and within the countries in the Community. Thus the person responsible for authorizing the use of resources (including his own time) is not also responsible for paying for them. While there is no clear limit to the amount of resources which might contribute to the care and comfort of some patients, the total which can be supplied at any time can be limited by what is currently available (for example, by the number of doctors and by the number of hospital beds - their level of staffing and the equipment provided). The supply of professional manpower and skilled staff cannot be increased in the short run.

It is therefore helpful to distinguish between user demand (the extent to which health care is sought) and professional demand (what the authorizing health professions decide is 'need').

USER DEMAND

The following are among the factors which may have increased demand:

(i) in some countries the proportion of the population covered by compulsory health insurance schemes has increased since 1966. The change in the coverage of health insurance in the nine countries is shown in Table 4.

At first sight it may seem obvious that the extension of the coverage of health insurance will increase costs. The relationship is more complex than appears at first sight for the following reasons:

Table 4

The coverage of health insurance or health services 1966 and 1975 (including voluntary members of the main health insurance scheme)

country	1966	1975
Belgium	75	85
Denmark	90-95	100
France	93.6	98
FR of Germany	85.6	90
Ireland	39[1]	85[1]
Italy	85[2]	94
Luxembourg	99	99
Netherlands	70	70[3]
United-Kingdom	100	100

[1] Coverage varies for different benefits. The figures quoted are for hospital care where coverage is highest.

[2] Only about three quarters of the insured population were entitled to pharmaceutical benefits.

[3] By 1975 the whole population was covered for long stay hospital care.

(a) The extension of coverage for services which are 'supply limited' such as hospital services may not lead to greater costs unless supply is increased in response to potential demand.

(b) Being covered for health insurance does not mean that services are necessarily provided free at time of use. Moreover, such countries as Belgium, France and Luxembourg reimburse the patients for part or the whole of the cost. The share of the cost falling on patients may have been increased during a period when health insurance has been extended.

(c) The section of the population brought into the health insurance scheme may previously have been largely covered by private insurance. Thus, while costs have been shifted from the private sector to the public sector, it is not necessarily the case that the actual costs are greater. Indeed the cost per person covered

may be lower under the health insurance fund than under private insurance because, for example, doctors and hospitals impose higher charges on private patients.

(ii) In some countries where the whole population is not covered by health insurance funds or where substantial costs are left to be paid by patients (for example, France) the extent of voluntary private insurance may have increased or there may have been a shift from private cash insurance to private service insurance as in the Netherlands. It is known what effect such changes have on the total cost of health care.

(iii) What is covered by the different schemes has been extended in some countries. For example, from 1974 a free family planning service was introduced in the United Kingdom, from 1972 care in psychiatric institutions was added to the health insurance scheme in Belgium. In the Netherlands the whole population has become insured against the cost of long term care in hospitals and other institutions. In Italy the self-employed were made eligible for pharmaceutical benefits from 1972 onwards, for which they were not previously covered.

(iv) Population migration, changes in family structure and the trend towards a higher proportion of women in paid employment have probably reduced the extent to which families care for sick persons at home.

(v) There is a general trend for people to be less willing to tolerate pain or discomfort and seek help from the health services for conditions and problems which they would not have taken to the health services in the past.

(vi) It is believed that with improved education and in response to media pressure patients seek out what they perceive as better or more sophisticated health care. In countries where the patient can go directly either to a general practitioner or a specialist, an increasing proportion of medical acts are being performed by specialists. Patients also expect a higher standard of personal and counselling services. In response to this demand, more receptionists, secretaries and social workers are employed. In the psychiatric hospitals there is public pressure to improve staff ratios and provide more individualized services. In some countries pressure groups have been campaigning for the improvement and extension of services.

The doctor consultation rate does not indicate changes in the extent to which patients seek health care as it includes health examinations, follow-up and other consultations which were recommended or suggested by the doctor. Comprehensive information on the doctor consultation rate is not available for all countries in the Community. In the United Kingdom the most recent data indicates a consultation rate for general

practitioners lower than in the early nineteen fifties. In other countries in the Community such as Belgium and France the trend has been upwards. One possible explanation for the large differences in the consultation rates of the different countries of the Community is that they tend to be higher and to increase where doctors are paid on a fee-for-service basis.

THE NEED FOR HEALTH CARE

The following are among the factors which may have increased the need for health care:

(i) The decline in the birth rate over the period 1966 to 1976 in many countries of the Community has made it possible to spend less on maternity services and young children. But this potential saving has been greatly counteracted by the increasing proportion of the population in the older age groups in all countries in the Community except Ireland. The proportion of the population over 65 in the years 1965, 1970 and 1975 is shown in Table 5 below.

Table 5

The proportion of population 65 and over

(EEC 1965-80)

country	1960[1]	1970	1975	1980 projected
Belgium	12.0	13.4	13.9	13.8
Denmark	10.7	12.4	13.3	14.2
France	11.6	12.8	13.3	13.8
FR of Germany	10.9	13.3	14.6	15.3
Ireland	11.2	11.1	10.9	10.8
Italy	9.5	10.6	12.2	13.1
Luxembourg	10.8	12.7	13.2	13.5
Netherlands	9.0	10.2	10.8	11.5
United Kingdom	11.7	12.8	14.0	14.9

1 Source: Social Report 1976

In Germany it is found that pensioners cost health insurance 1.7 times more than the remainder of the insured and in France 1.76 more. In the United Kingdom, it is calculated that the cost per head of the National Health Service is six times greater for a person over the age of 75 than for a person aged 16 to 64: over the period 1966 to 1975, expenditure on the National Health Service needed to grow at nearly 1% a year in real terms to provide the same standard of service to the changing age and sex groups of the population. The changing age structure is an important cause of the changing morbidity of the population - particularly the greater incidence of the chronic diseases of the older age groups. It is, however, of interest to note that no clear relationship can be found between the proportion of population over the age of 65 and the percentage of GNP devoted to health services in the different countries of the Community (see Table 6).

Table 6

Proportion of population aged 65 and over and estimates of the cost of health services as a percentage of GNP in 1975

Country	Population 65 +	Cost of health services as % of GNP
Belgium	13.9	6.2
Denmark	13.3	6.1
France	13.3	6.7
FR of Germany	14.6	8.0
Ireland	10.9	7.0
Italy	12.2	5.2
Luxembourg	13.2	(3.5)
Netherlands	10.8	(8.4)
United Kingdom	14.0	5.4 (England and Wales)

(ii) Changes in behaviour such as the increase in motor accidents, increased concumption of alcohol and the long-term effects of heavy cigarette smoking may have added to the need for health care. It is also suggested that greater urbanization results in a greater need for health care. On the other hand, the decline in the incidence of the main infectious diseases in the Community has continued during this period.

SUPPLY

The following are the main forces on the supply side which may have led to higher costs:

(i) In many of the countries of the Community staff working in the health services have improved their relative position in the wage and salary markets as a result of the growth of trade-unionism, legislation concerning equal pay for men and women and the need to offer more attractive remuneration to recruit and hold staff for work in hospitals which need to provide 24 hour services.

(ii) Hours of work have also been reduced so that more staff are required to provide a 24 hour service. In Germany, for example, working hours have fallen from 60 a week in 1955 to 40 a week in 1975.

(iii) The introduction of new techniques of diagnosis and new treatments have generally recquired more staff time and equipment per patient. While some new medical equipment (e.g. autoanalysers) saves labour costs per unit of output, it greatly increases the demands which can be met. Other new equipment (such as scanners) adds to manpower requirements. More expensive and, in many cases more effective pharmaceuticals have been replacing less expensive products in the treatment of particular conditions. Their use may make hospital stays and surgery unnecessary or shorten their duration. In some cases, however, hospital stays may be lengthened because of side-effects.

(iv) In all nine countries the ratio of doctors to population has been increasing. The number of doctors (and dentists) per 10 000 population for the different countries of the Community is shown in Table 7.

The increase has been most rapid in Belgium, Denmark, the FR of Germany, Italy and the Netherlands. This may have enabled patients to make more visits a year. As there is no evident limit to the actions which doctors can take which might help their patients, the greater ratio of doctors may have led to an increase in medical acts per patient and the encouragement of further visits by the doctor. This trend may be partly a response to new techniques of diagnosis and therapy but it may be strengthened by three types of pressure:

(a) <u>The payment system</u> - If, for example, the doctor is paid for each pathology test or X-ray as under the health insurance schemes of Belgium, the FR of Germany, France, Luxembourg and the Netherlands, he is under a continuous incentive to order more tests. The available

data suggests that more pharmaceuticals are prescribed in countries with fee-for-service payment for doctors. (See: Study of pharmaceutical consumption).

(b) Fear of litigation - Tests may be oredred not becausd the doctor expects them to help him in his diagnosis but because, if anything should go wrong, it might help in his legal defence. 'Defensive medicine' is believed to be a cause of increasing costs in Germany.

(c) The sales pressure of supplies - It is in the interest of the pharmaceutical industry to persuade doctors to make extensive use of their new products. Similarly, more and more sophisticated medical equipment is being produced and doctors are persuaded to buy it or request that it be purchased.

Table 7

Physicians per 10 000 population

Country	1965	1975
Belgium [1]	13.0	18.9
Denmark	13.0	17.5(1976)
France [1]	12.1	14.7
FR of Germany	15.7	19.4(1974)
Ireland	10.5(1961)	12.1
Italy [1]	16.0	19.9(1973)
Luxembourg	9.9(1964)	10.8(1974)
Netherlands	11.7	16.0
United Kingdom (England and Wales)	11.5	13.1(1974)

[1] Including doctors practising dentistry or specialists in odontology.

Definition: Doctors working in any medical field (practice, teaching, administration, research, laboratory).

Source: WHO Annual Statistical Summaries 1965 and 1977.

Table 8

Hospital beds per 10 000 population

(EEC 1965 and 1975)

Country	1965		1975	
	Beds per 10 000	% Occupancy	Beds per 10 000	% Occupancy
Belgium	77.1	-	88.9(1974)	-
Denmark	90.1	88.6	105.0(1976)	-
France	102.1(1964)	- (1964)	-	-
FR of Germany	106.0	91.3	118.0	83.3
Ireland	135.7(1964)	- (1964)	-	-
Italy	97.5	70.0	105.8(1972)	78.9(1972)
Luxembourg	116.2	79.9	107.8	81.8
Netherlands	75.2	92.2(1964)	-	-
United Kingdom[1] (England and Wales)	98.3	84.5	85.6(1974)	81.2(1974)

[1] National Health Service hospitals only.

Definition: Beds regularly maintained and staffed in all types of hospitals.

Source: WHO Annual Statistical Summaries 1965 and 1977 (p.193-4).

(v) The number of beds - The ratio of hospital beds to population has risen in most countries of the Community during the period 1966 to 1975. It has, however, fallen in both Luxembourg and the United Kingdom (England and Wales). The changes over the ten-year period are large - for example, a growth of provision of over 10% in Belgium, Germany and Italy and a fall of over 10% in the United Kingdom (England and Wales). The number of hospital beds in each country in the Community is shown in Table 8 above.

What is striking about this table is the large variations in the number of available beds per thousand in the different countries of the Community. These variations cannot be explained by differences in the proportion of the population over the age of 65.

Table 9

Proportion of population 65 and over
and the number of hospital beds per 10 000

(EEC 1975)

Population 65+		Hospital beds per 10 000
Belgium	13.9	88.9 (1974)
Denmark	13.3	105.0 (1976)
France	13.3	-
FR of Germany	14.6	118.0
Ireland	10.9	108.0
Italy	12.2	105.8 (1972)
Luxembourg	13.2	107.8
Netherlands	10.8	-
United Kingdom	14.0	85.6 (E & W 1974)

The explanation is likely to be found among the following factors:

(a) The extent to which other types of institution are available for the care of persons who might otherwise be cared for in hospital. (This raises again the question of what types of institution countries classify as hospitals.)

(b) The admission rate.

(c) The length of stay.

Both (b) and (c) may be influenced by the extent to which home care services are developed. The subject would clearly warrant closer examination.

The number of patients in hospital can be limited by the number of beds available. If more staffed beds are provided they tend to be used. Where hospitals are paid per day of care, there is an incentive on the hospital to extend the length of stay to secure payment for as high a proportion of staffed beds as possible unless patients are waiting to be admitted. Moreover, the cost falling on hospitals tends to be lower for later than earlier days of stay so that high occupancy is more profitably attained by longer stays than more admissions. It is only in the last ten years that all countries in the Community have introduced controls over hospital construction and many hospitals were under construction when these controls were introduced. Of all countries in the Community, France has the highest proportion of beds in profit-making hospitals - most of

them owned by doctors. In the period 1963 to 1972 the number of beds in profit-making hospitals rose by 69% and in non-profit-making hospitals by 11%.

(vi) The cost per day of hospital care has been increasing in real terms. One reason for this has been the renewal and upgrading of hospital buildings. The running costs of new or upgraded hospitals tend to be substantially higher than the running costs of old hospitals. This is partly because they may be built with a higher proportion of single rooms which require more staff per bed. Secondly, the opportunity has usually been taken to incorporate such improvements as air conditioning, more expensive heating systems, oxygen supplies piped to each bed and modern communication systems. Thirdly, space has been provided to house new medical equipment and the staff to operate it. In France it has been found that the modernization of a hospital leads to a loss of 30% of the beds and an increase in the daily rate of 35%. Quantative information is not available indicating the proportion of hospital beds in accomodation built or radically upgraded in the last ten, twenty or thirty years in the different countries of the Community. Nor is information available for capital expenditure on hospitals over the past thirty years in all countries. These are subjects which warrant further investigation.

D. ACTION TO CONTROL EXPENDITURE ON HEALTH SERVICES IN EACH COUNTRY

In this section of the report, a summary is presented of the action taken in each country to control expenditure on health services.

BELGIUM

The major part of health service expenditure in Belgium is financed by health insurance which covers about 99% of the population. The patient is partly or wholly reimbursed for payments made to providers. The six health insurance funds make collective agreements with providers on professional fees (e.g. doctors and dentists). The Minister has the formal power to ratify these agreements with providers. Both doctors and dentists are paid on a fee for service basis and with some exceptions patients are reimbursed for 75% of the cost of these services. Patients are wholly reimbursed for the daily charges of hospitals in general wards for the early days of stay. At the beginning of 1976, 63% of the hospital beds were in private hospitals, most of which were non-profit making.

Although about a quarter of the cost of health insurance is subsidized by the Government. The Minister has to approve the proposed level of health insurance contribution but it would be politically very difficult for a Minister not to agree to what is proposed.

The methods which the government uses to limit the growth in the cost of health insurance are:

(1) controlling the number of hospital beds and 'heavy' medical equipment;

(2) limiting increases in the rates charged for a hospital bed-day;

(3) encouraging the development of substitutes for care in hospital;

(4) limiting the growth of pharmacies and regulating pharmaceutical prices;

(5) increasing the share of costs falling directly on patients;

(6) encouraging preventive action.

The actions taken do not include any attempt to monitor control or limit the actions of doctors. Since the doctors' strike of 1974, the Government has been unwilling to enter into this contentious area other than to use its influence to try and secure that as many doctors, dentists and other professionals as possible enter into the agreement on fee levels made between the sick funds and the representatives of the doctors and thus charge not more than the agreed fees.

The actions taken under the six headings above are described below.

Control of hospital beds and heavy equipment

The Minister of Public Health and Family Affairs has the power (under the Hospital Act of 23 December 1963) to recognize a hospital or a hospital service. If recognition is withdrawn a hospital has to close. Under the law of 6 July 1973 it is forbidden to build, extend, convert or carry out works on a hospital or a service in a hospital which increases the number of beds or changes its purpose if the works do not fit in with the hospital plan. Criteria for hospital requirements have been laid down after having taken advice from the National Committee for Hospital Programming. In each of the three regions of Belgium there are Regional Committees of Hospital Programming which examine plans submitted for changing hospitals or building new ones and advise the Minister. Maximum ratios between beds and population (or births in the case of obstetric services and services for children) have been laid down in Royal Decrees of 1976 and 1977. In addition 14 categories of heavy medical equipment have so far been designated which cannot be installed without the approval of the Minister.

Control of the daily rate for hospital care

The Government can only control total staff establishments in the 37% of beds (at 1 January 1976) in local authority hospitals. But in a circular of August 1977, maximum ratios of nursing staff to beds were laid down for all general and psychiatric hospitals varying according to the number of beds, the range of percentage occupancy and the type of hospital or hospital service. The main control of costs is through the daily rate which hospitals are allowed to charge. The daily payment does not cover certain specialty pharmaceutical products which are not reimbursable and extra payments for accomodation other than in a communal ward. The cost of medical and paramedical technical services are

reimbursed separately - normally only in part. Three-quarters of the daily payment is reimbursed by health insurance and one quarter is paid by the Government. The rate per day can vary between hospitals and between specialties in hospitals. All rates have to be approved by the Minister. Hospitals are able to negotiate price increases based on the rate established in the previous year. In August 1977 the Minister laid down maximum rates of increase he would approve for particular classes of hospital or hospital service.

Encouraging substitutes for hospital care

An act passed in 1978 gave the Minister power to approve integrated home nursing and medical care services and homes for the elderly which made it possible to prevent admission to hospital or reduce the length of stay particularly in the care of the chronic sick.

Such programmes can now be subsidized by the health insurance funds or other bodies financing services. Home care services in Belgium have so far been much less developed than in such countries as the Netherlands or the United Kingdom. Home nursing services are provided by some town councils, by the White and Yellow Cross Organizations and some private organizations. Part of the cost of home nursing services can be reimbursed by health insurance.

Regulating pharmacies and the price of pharmaceuticals

Until 1970 there was no restriction on the opening of pharmacies. The present criteria were established in a decree of 1977 which laid down maximum number of pharmacies for municipalities according to the number of population and the dispersal of it.

Under a law of July 1975, maximum prices for pre-packed pharmaceuticals and other medicines are fixed by the Minister of Economic Affairs.

Changes in reimbursement rates

From April 1978 categories of patients in a room for more than two persons have been required to pay BFR 150 or BFR 250 per day from the 90th day in hospital. The previous charge of BFR 50 continues from the 41st day to the 89th day. There are extra charges for rooms for one or two persons for each day of care. The payments are for the hotel cost of care. The objective is to lighten the cost of health insurance.

DENMARK

Health care in Denmark is provided on a service rather than insurance basis. The whole population is entitled to free hospital care, the services of a general practitioner, home nursing and preventive services. Dental services are partially covered (67% of the cost in the case of people born before 1945 and 75% of the cost for people born after 1945). School dental care is completely free. The supply of spectacles is partially covered in the case of children and pensioners, and almost completely for those with very low visual power.

The establishment of doctors in general practice is controlled by the counties in conjunction with a special committee of general practitioners. There is no restriction on the opening of practices in the case of dentists and opticians. School-dentists are salaried public employees.

The municipalities finance home nursing, public health nursing, school medical officers and vaccinations and also nursing homes. 50% of their expenses are reimbursed by the national government.

The counties finance general practitioners, dentists, medicines and physiotherapy treatments. All general practitioners are paid by one of two systems. In Copenhagen the system is an annual capitation payment per listed person. Outside Copenhagen they are paid a basic salary per person plus fees for specific services (according to a special list) and for out-of-hours services. In October 1977, 91.4% of the population had registered with a specific family doctor for at least a full year ('group 1 patients'). The remaining 8.6% had, for extra payment, exercised the option to have free access to any general practitioner or specialist. The doctor concerned receives from the public sickness scheme a standard fee, and the patient must pay the extra amount directly to the doctor.

The counties also provide the hospital services. Nearly all specialists are based on hospitals and they are paid whole-time (and in a few cases part-time) salaries for their hospital work. The counties receive from the general government a subsidy to the tax-basis (called block grant) which is also adjusted according to 'objective criteria' of the need for services in each county. For 1976/77, it was estimated that approximately 40% of the counties' running expenses would be covered by these subsidies. Any extra expenditure has to be financed out of the taxes levied by the counties (or by loans in critical situations). The central government is thus in a strong position to influence the rate of expenditure on hospitals as it determines the total level of grant made to the counties. The central government can also place a limit on the extent to which loans can be raised - particularly foreign loans. It is more difficult to control the current expenditure of the municipalities.

The measures taken by the national Government to reduce costs are the following:

(1) reducing the amount which regional and local authorities were authorized to spend on capital account;

(2) influencing the expenditure of the counties and the municipalities;

(3) rationalizing the hospital system, and surveying hospital apparatus;

(4) encouraging alternatives to in-patient care;

(5) limiting entry to medical school;

(6) preparing priorities for the development of the health services;

(7) encouraging prevention.

Re 1. The reduction of capital expenditure

All hospital building schemes have to be approved by the Minister for Internal Affairs who takes advice from the National Health Service and the National Hospital Council. In the perspective plan II 1972-1987 the project team which included representatives from the Ministry of Economic Affairs, the Ministry of the Interior, and the National Health Service suggested a more restrictive hospital policy including provisions to halve the real level of capital expenditure. As a substitute there should be an expansion of ambulatory activities related both to the primary health care services as well as to the hospitals. The team suggested less ambitious goal-setting, comprehensive planning of the more long-term type, better control and evaluation, and improvements in health care management. Little action has followed from these recommendations.

Influencing the expenditure of the counties and the municipalities

In spite of the fact that all highly and medium-educated manpower employed by the counties and municipalities is subject to central control, the expenditure on health services is still increasing in 1977.

Rationalizing the hospital system

The ultimate aim is to reduce the number of general and psychiatric beds from 8.0 per thousand in 1976 (this figures excludes nursing home beds) to 7 per thousand or less and prevent overlapping and duplication. It is however politically difficult

to close or transform hospitals in Denmark. Yet it has already been done in about 26 cases in the years 1970-1977. It is also the aim of policy to concentrate out-patient facilities on the larger hospitals. Surveys of the more sophisticated apparatus in existing hospitals are being undertaken with a view to possible central control of purchases of 'heavy equipment'.

Encouraging alternatives to in-patient care

To reduce the need for admission to hospital and cut lengths of stay, the primary health-care system and home-care services are being strengthened. Home nurses, visiting paediatric nurses, and general practitioners are being encouraged to work more closely together. Day-hospital care and out-patient surgery are also being encouraged to reduce the need for in-patient care.

Limiting entry to medical school

In 1975 a total of 1 408 students matriculated to medical education, and 742 students graduated.

From the year 1976 quotas have been established for entry. Only 800 students are allowed to matriculate each year, and it is planned that about 600 a year will graduate.

Priorities for the Health Services

In 1974 a 'priority committee' was appointed by the Government which worked in four subcommittees. The 'priority committee' has completed its work, and in May 1978 the Minister for Internal Affairs presented the report to parliament.

Encouraging prevention

Health education is being promoted with a particular emphasis on occupational and environmental health.

Under discussion

1. Monitoring the total health care of clients/patients by the use of a 'central person register number' and integrated data collected locally and regionally, and evaluated centrally should be possible. Some type of a life-long, problem-orientated, computer record is being considered.

2. The profiling of the practices of general practitioners and specialists is a matter of great concern.

THE FEDERAL REPUBLIC OF GERMANY

The compulsory Health Insurance Scheme in Germany paid for services provided to over 90% of the population (including voluntary contributors). There are over 1 400 separate health insurance funds which negotiate fees with doctors' and dentists' associations at the provincial ('lander') level, taking into account the recommendation made at the federal level after discussion between the associations of health insurance funds and the professional associations. Each fund has to provide certain services but can provide additional services if it decides to do so. The rate of contribution varies between the different funds. The fund pay doctors and dentists indirectly and pay hospitals and pharmacists directly: the only payments falling on patients are for part of the cost of prescriptions, dentures, transport up to DM 3.50, any extra charges for higher classes of accomodation in hospital, or for use of a doctor or hospital other than the nearest suitable one. Each health insurance fund is nearly autonomous in fixing the level of contributions levied on the insured: government contributions to the cost of health insurance are confined to certain groups (e.g. farmers and students).

Over half the hospital beds are in public hospitals - mainly owned by public authorities, mostly Communities. Over a third of the beds are in non-profit hospitals and about a tenth are in private profit-making hospitals. The daily rates which may be charged by all hospitals covered by the law on hospital financing are fixed by the 'Lander'. Under a Law of 1972 the costs of buildings, equipment and apparatus for such hospitals are paid for by grants from the government with the cost shared between the Federal Government, the 'Land' and the municipality concerned. Grants are only paid for hospital buildings which conform to the hospital plans prepared by each 'Land' and the Federal Government can impose a ceiling on the grants it will provide. There are no direct powers to require an existing hospital to close because it is surplus to requirements.

The measures taken to limit the growth of cost are the followings:

(1) controlling capital expenditure on hospitals under federal law;

(2) trying to restrain the growth of the daily rates charged by hospitals;

(3) limiting the growth of doctors' and dentists' fess by federal recommendations and contracts on lower levels;

(4) encouraging doctors to place a ceiling on the growth of expenditure on prescribing above which sanctions might be applied. A list of drugs is being prepared which by taking account of both efficacy and cost makes it easier to compare different drugs;

(5) limiting what health insurance is prepared to pay for and increasing certain charges falling upon patients under federal law;

(6) encouraging developments under which the same doctor will be responsible for care inside and outside hospital;

(7) encouraging the construction of nursing homes;

(8) encouraging preventive action;

(9) establishing under federal law a commission for 'Concerted Action on Health'.

Controlling hospital capital expenditure

The 1972 law which required each of the three level of government to contribute to the cost of hospital capital expenditure and required new developments to conform to 'Lander' plans has led to a reduction in the real level of capital expenditure through the ceiling set by the Federal Government. Pressure for each local community to have its own hospital is strong and it is extremely difficult politically to secure the closure of any hospital. In so far as 'Lander' are prepared to plan for a reduction in hospital beds in the future, the 1972 law enables hospital capital expenditure to be restricted. As many new hospitals are currently under construction it will be some time before a more restricted building policy can influence running costs, but expenditure on hospital capital construction has been falling in real terms over the past few years.

Limiting the growth of the daily rates charged by hospitals

The 'Lander' have the power to fix the daily rates and a restrictive policy is being applied. The Federal Government has only power to make recommendations on this matter.

Placing a ceiling on payments to doctors

An agreement to limit costs was reached between the health insurance funds and the doctors associations in 1976. Any increase in the volume of services rendered above the limit would lead to a proportionate reduction in the level of fees to keep the annual growth in cost to 8%.

A new law to reduce the cost of health insurance came into effect in the middle of 1977. Under this law criteria are laid down for adjusting the level of doctors' fees. Account must be taken of the wages on which contributions are levied, the costs of the doctors' practices, the time he works and the extent of services rendered. The aim was to bring the increase in fees more in line with the general increase in incomes and strengthen the position of the health insurance funds in negotiating levels of fees.

Secondly the same law established a uniform structure of fees for doctors and dentists. The aim was to reduce the relative fees for technical medical services (such as pathology and laboratory services and X-rays) and increase the relative fees for the consultation. Thirdly, the Commission for the Consistent Charging of Fees will in future consist of equal numbers of representatives of health insurance funds and of representatives of doctors. Fourthly, the Law also provides for agreements to be made between health insurance funds and dentists and dental technicians. The particular aim was to control the prices charged by dental technicians.

Limiting the cost of prescription

Under the law to reduce the cost of health insurance, health insurance funds and doctors associations are required to fix maximum levels of expenditure on pharmaceuticals under health insurance for each fund. In fixing these the negotiators are to take account of recommendations issued by doctors' organizations and the health insurance funds at the federal level. If the maximum is exceeded to any appreciable extent and cannot be accounted for by exceptional circumstances (such as epidemics) an investigation must be made into the prescibing behaviour of doctors under health insurance: doctors found in this investigation to have prescribed excessively will be reported to their professional associations which can reduce the remuneration of individual doctors.

The Ministry of Health has set up a committee of enquiry to make comparative surveys of pharmaceuticals taking account of their efficacy and price. This information will be circulated to doctors to encourage economical prescribing.

Charging what health insurance is prepared to pay for and raising charges falling on patients

Under the law to reduce the cost of health insurance:

(a) The cost of home nursing help will be able to be reimbursed where this can prevent the patient from being admitted to hospital.

(b) No longer will the following be reimbursable by health insurance:

(i) simple medicines and bandaging materials used for mild indispositions;

(ii) the cost of home help where members of the family can take over the patient's work themselves.

(c) The financing of cures at watering places and health resorts are made subject to more stringent medical requirements.

(d) The costs falling direct on the patients are increased for:

(i) transport;

(ii) false teeth and crowns;

(iii) medicines and bandaging - a minimum charge per item of DM 1 has been introduced.

Providing legal authority for measures to encourage continuity of medical care

The present extensive separation between specialists who work with hospital in-patients and specialists who work outside hospitals often results in the duplication of diagnostic tests. Encouragement is being given to the development of out-patient activities by doctors working in hospitals and in-patient activities by doctors who at present only work outside hospitals.

The development of nursing homes

As part of 'Lander' activities, nursing homes are being built to care for patients who do not need the full and expensive facilities of a hospital.

Encouraging prevention

An extensive programme of health education has been launched with particular emphasis on the promotion of personal hygiene, active sport and the use of preventive measures, occupational health, and health education in spas and rehabilitation centres.

Concerted Action Commission

Under the law to reduce the cost of health insurance a national commission for 'Concerted Action on Health' has been established under the auspices of the Ministry of Labour and Social Affairs. Members include representatives of the statutory health insurance schemes, private insurers, doctors, dentists, hospitals, pharmacists, the pharmaceutical industry, trade unions, employers and the 'Lander'.

The task fo the Commission are:

(a) to draw up guidelines for the future adjustment of doctors' fees and for establishing 'Lander' maxima for the cost of prescriptions. (In the event of agreement not being reached this responsibility will fall on the doctors organizations and the health insurance funds.);

(b) to make further proposals to increase the effectiveness and efficiency of health care.

FRANCE

The major part of health service expenditure in France is financed by health insurance covering over 98% of the population. But the share of the total cost not covered by national health insurance is substantial - over a quarter but about 6% of the cost is covered by mutual insurance. The proportion of the cost paid for by health insurance varies by the type of care. It is low for care in hospital and high for minor 'comfort' drugs. While health insurance funds pay their share of costs directly to hospitals, the patient is reimbursed for part or whole of the cost of other payments made to providers. As distinct from Belgium, the Government in France makes no regular contribution towards the main funds of health insurance. Agreements are made between the health insurance funds and the professions providing services. Only 4% of doctors have refused to accept the agreement and thus to apply the negotiated tariff of fees. It should however be noted that about 20% of doctors under the agreement have the right to exceed the standard tariff of fees. The Government has the right to modify the level of contributions paid to health insurance funds after discussion with the representatives of the health insurance funds.

About a third of the hospital beds in France are in the private sector: 56% of the latter are in profit-making hospitals mainly owned by doctors and 44% are in non-profit making hospitals. Over 80% of private hospitals have made agreements with health insurance under which insured persons can be treated under the same conditions as in public hospitals, so that the percentage of the cost falling on the patient is the same as in a public hospital. This is normally 20%, though the whole cost of maternity and surgical care (apart from minor surgery) is reimbursed. Extra charges can be made for extra amenities, even in a public hospital. The remaining hospitals are public hospitals.

The measures taken by the Government to limit the growth of the cost of health insurance are similar to those taken in Belgium:

(1) controlling the number of hospital beds and 'heavy equipment';

(2) limiting the rates charged for a hospital day;

(3) regulating pharmaceutical prices and the sales promotion activities of pharmaceutical firms;

(4) restricting what may be reimbursed under health insurance and increasing the share of costs falling on patients;

(5) the development of medical profiles;

(6) restricting the future output of doctors by raising examination standards in the early years of the course;

(7) examining ways of encouraging care outside hospital;

(8) encouraging preventive action;

(9) assisting the financial position of health insurance by reducing VAT charged on pharmaceuticals.

Control of hospital construction and heavy equipment

Under a law of 1958 it not possible to build or extend a hospital without the approval of the Minister of Health. Criteria have been established on the number of hospital beds of different types requires - a 'Carte Sanitaire' for each region and health district. The control applies to both public and private hospitals.

The Ministry has the power to withdraw the agreement for a private hospital which does not meet requirements of minimum standards. In that case insured patients admitted to that hospital are not reimbursed. Capital expenditure on hospitals is, with few exceptions, being limited to the replacement and upgrading of old hospitals.

Eleven categories of heavy equipment cannot be installed in a hospital without the approval of the Minister of Health who is advised by a national sanitary equipment commission and regional commissions.

Limiting the rates charged for a hospital day

The rates of public hospitals are fixed by the Prefect of the Department. The rate of increase in rates over the previous year is kept strictly under control. From 1945 the establishment of medical staff in public hospitals has been centrally controlled.

Experiments are being made in financing hospitals on a budget basis. There is also a local experiment under which only hotel costs are charged on a daily basis leaving drugs, X-rays, pathology and other services to be charged on the basis of actual costs. The aim of these experiments is to reduce the incentive on the hospitals to retain patients longer than necessary.

Pharmaceutical prices and sales promotion

The prices of pharmaceuticals have been tightly controlled since 1968. They are claimed to be the lowest among all countries in the Community.

From 1976 manufacturers were only allowed to send samples to doctors at the request of the doctor.

Reimbursement and co-payment

From 1977, the following changes in the reimbursement system were introduced:

(a) A new category of medicines of lesser importance was introduced for which patients had to pay 60% of the cost leaving only 40% to be reimbursed by health insurance.

(b) In the case of physiotherapy services the share of the cost paid by health insurance was lowered from 75% to 65%.

(c) Psychotherapy services became only subject to reimbursement if prescribed by a doctor and authorized in advance by the medical control staff of health insurance funds.

(d) The reimbursement of the costs of ambulances was made subject to new conditions.

Medical Profiles

A system of statistics has been established to bring together all the activities of each doctor caring for health insurance patients (consultations, X-rays, pathological tests, prescriptions). In each Department, a committee has been established consisting of representatives of doctors and of health insurance funds to examine these profiles. A doctor whose profile is verty different from that of average doctors of the same specialty in the same administrative area is to be notified of the fact and in extreme cases excluded from health insurance practice. The procedure has been formally agreed with representatives of the profession but the policy has not so far been actively applied for various reasons including disagreements among the different organizations of doctors.

The future output of doctors

There are no quotas for the number of students entering medical schools. The output of doctors is however being restricted by raising the standard required in the examinations at the end of the first and second years. A substantially lower proportion of students now get as far as the third year of the course.

Alternatives to hospital care

Most home nursing is done by private independent professional nurses. This service is reimbursed by health insurance. Some municipalities have home nurses in their employment particularly in the Paris area.

The thrust of policy in France is to encourage the development of out-patient departments attached to public hospitals whose functions include preventive work (e.g. antenatal examinations) and to attempt to develop cheaper alternatives to hospital care for the elderly and for physically and mentally handicapped children.

Prevention

A major campaign of health education has been launched with a particular emphasis on road accidents, nutrition with a special emphasis on pregnant women, cigarette smoking and excessive consumption of alcohol.

IRELAND

About 40% of the population is entitled to all health services without charge. A further 45% is entitled to hospital services free. Small contributions (IRL 0.50 a week from insured workers) are collected from the 45%. The remainder of the population can insure against the cost of health care trough a voluntary health insurance scheme. By far the major part of the cost of providing health care is paid out of national taxation. About 47% of acute hospital beds are in public hospitals administered and provided with budgets by the appropriate Health Board. 45% of beds are in non-profit voluntary hospitals which are provided with annual budgets by the Department of Health to cover the cost of the treatment of eligible persons. The remaining 8% are in private hospitals which receive subsidies towards the cost of eligible patients. Hospital doctors in Health Boards hospitals are salaried. Doctors, other than consultants, in non-profit voluntary hospitals are paid by salary. Consultants in these hospitals are, in general, remunerated on a per diem per patient basis. General practitioners are paid on a fee-for-service basis. Specialist services for the bulk of the population are provided at the out-patient and in-patient departments of the hospitals.

The following methods have been used by the Government to control the growth in costs:

(1) freezing and subsequently restricting the growth in real expenditure of Health Boards;

(2) cutting capital expenditure;

(3) developing profiles of general practitioners' work;

(4) rationalizing the hospital system;

(5) preparing a recommended list of pharmaceuticals;

(6) promoting prevention.

Freezing and subsequently restricting the real expenditure of Health Boards

As a result of the serious economic difficulties of the country, the Government decided to provide Health Boards with the same resources in real terms on current account in 1976 as they had had in 1975. This followed a period of considerable real growth. As the expenditure of hospitals was subject to budget limits, they could be provided with 'non-growth' budgets in 1976. The Department of Health in association with a statutory Hospitals Council has total control of medical manpower entering the health services. Family doctors need Health Board approval to join the community medical services. Similarly the Department of Health has control of medical staff establishments both at public hospitals and at publicly financed non-profit voluntary hospitals. The 'open-ended' part of Health Boards expenditures consist of the total amount of fees to general practitioners and the cost of pharmaceuticals they prescribe. These elements amount to about 12½% of their expenditure. Health Boards were told that any increase in the cost of this part of their services had to lead to economies elsewhere. The policy was successful. The final expenditure was only about 1% more in real terms than originally planned. The current budgetary control arrangements include the fixing of permissible annual levels of expenditure for health boards and other health agencies and monitoring by the Department of Health of expenditure as compared with approved budgets on a monthly basis.

Dental, aural and ophthalmic services are provided free of charge to primary school children and persons in the full eligibility category which is about 40% of the population.

Reducing capital expenditure

The budget for capital expenditure was cut in real terms by about 12% between 1973 and 1976 and was increased in real terms between 1976 and 1978 by about 51%.

Developing profiles of general practitioners' work

Patients have to register with a general practitioner. Statistics are kept of the number of consultations for which doctors charge and of the cost of their prescriptions. These statistics can be related to the patients for whom they are responsible. Visits can be made by doctors employed by the Health Boards to doctors whose costs appear to be considerably above the average in their area. Visits are made by doctors employed by a central monitoring body representative of the Health Boards.

Rationalizing the hospital system

In the long run, it is planned to rationalize the hospital system by reducing the number of hospital beds relative to

population from the present figure of 5.1 per thousand to 3.6 In view of the political difficulty of closing hospitals, it is envisaged that a number of general hospitals may continue as community hospitals under the care of general practitioners to provide for patients who do not require the services of consultant staffed general hospitals.

A recommended list of pharmaceuticals

A formulary which will provide guidelines related to the efficacious and the cost-effective use of drugs is being prepared for recommended use in the health service.

Promoting prevention

Prevention is strongly promoted both in the programmes of the Health Boards and in health education aimed at the public. The current emphasis in health education is on general fitness ('be active; be alive') promotion of hygiene; moderation in drinking and a campaign against smoking.

ITALY

Italy is completing a transition from insurance-based health care services where some 200 separate health insurance funds contracted for services from professionals and paid hospitals on a daily rate basis and many funds owned their own hospitals and specialist clinics to a national health service covering the whole population. Money collected by health insurance contributions with the addition of money raised in taxation is channelled in the form of grants (which will eventually be based on the population served) to the 20 regions which are autonomous political entities. So far this system of funding is only applied to the hospitals: the health insurance funds continue to pay doctors and pharmacists according to national agreements negotiated with providers by the funds. Ultimately it is intended that the regions will have the responsibility, taking account of national guidelines, not only to plan and finance the hospitals, but in accordance with national agreements made between the providers and the public authorities, pay general practitioners on a capitation basis, pay pharmacists for the drugs doctors prescribe and distribute funds to local health units. Specialists work partly in hospitals and partly in premises separate from the hospitals and are paid on a whole-time or part-time salaried basis. About 80% of hospital beds are publicly owned and funded on a budget basis. Contracts will be made for services in private hospitals and payment will continue to be on a daily basis for the services they provide to national health service patients. Dental and optical services are provided by part or whole time salaried professionals. Small charges are levied for these services. There are virtually no home care services in Italy.

One purpose of the reform is to secure 100% coverage of the population. A second is to secure a more equitable distribution of the money spent on health services. But a third and by no means subsidiary purpose is to change to a system of financing where the cost of health services can be contained and responsibility devolved on to the regions which can in turn devolve responsibility to local health units.

The particular features of the reform which help to contain costs are the following:

(1) the central government determines the level of hospital capital expenditure;

(2) public hospitals are budget limited;

(3) hospitals will be planned to operate as part of integrated local health services under local control;

(4) payment of doctors by capitation and salary is designed to contain costs;

(5) the administrative costs of insurance funds will be saved;

(6) special steps have been taken to limit the cost of prescriptions.

Controlling capital expenditure

Most hospitals are built by the communes but projects have to be authorized by the Ministry of Public Works, the Ministry of National Health and the Ministry of Finance. No hospitals can be built in the future which do not conform to the national hospital plan. No new projects are being started during the present transition to the full national health service.

Establishing budget limits for hospitals

The 1974 law changed the system of financing hospitals from payments of daily rates by the health insurance funds to budget financing through the regions. The system of financing hospitals by budget is designed to limit costs and remove the financial incentive to retain patients longer than necessary.

Planning hospitals into a system

A law of 1968 made provision for hospitals to be grouped together into hospital communities under common management. It is intended that they will ultimately be grouped together under local health units responsible for providing both hospital and community health services. Under the same law a national hospital plan and quinquennial hospital building programmes have to be established.

The regions have to prepare draft plans for their regions and establish regional and provincial hospitals as well as local general hospitals servicing 20 000 to 50 000 population. The Government has issued guidelines on the number of beds per thousand of different types upon which planning should be based.

Changing the method of paying general practitioners and specialists

There has been a steady transition from a position where the majority of doctors were paid as a fee-for-service basis under health insurance /ten years ago/ to the present position where general practitioners are paid on a capitation basis and specialists on a part-time or whole-time salaried basis. It was found under the largest sick fund (INAM), that the number of consultations per patient under fee-for-service payment was on average greater than under capitation payment. It was also found that the number of prescriptions per patient was always higher under fee-for-service than capitation payment. This last finding was particularly important in view of the fact that prescriptions amounted to about a third of the cost of health services in 1974. It is hoped to restrict the increase in the cost of both medical services and prescriptions by the new payment system.

Saving administrative costs

The administrative costs of running about 200 separate health insurance funds will be saved. In addition payment of doctors on a salaried or capitation basis rather than fees-for-services and financing hospitals on a budget basis rather than daily payments per patient will save administrative costs.

Prescribing costs

A new list of about 10 150 preparations has been prepared (before 1976 the list included more than 13 000 preparations) which are the only ones which will be paid for by the national health service. The prices of pharmaceuticals are strictly controlled.

LUXEMBOURG

Health Insurance covers nearly the whole population. While health insurance funds pay their share of costs directly to hospitals, the patient is partly or wholly reimbursed for payments made to other providers. The eleven health insurance funds make collective agreements with providers on professional fees and the daily rates to be charged by hospitals. From 1974, the level of contributions payable to each health insurance fund have been

laid down by the Government. The rate of the contributions will be fixed at a uniform level from September 1978. All doctors are required to charge the level of fees agreed with the sick funds. About a quarter of the cost of health insurance is subsidized by the Government. Of all hospital beds 33% are in private hospitals, 42% in public hospitals and 25% in hospitals run by the communes.

Although full figures are not available it is probable that the cost of health care in relation to national resources is lower in Luxembourg than in any other country in the Community. As a result the Government has not been unduly concerned about the question of cost until the last two years.

The following powers are available to the Government to restrict the growth in the cost of health care:

(1) controlling the number of hospital beds and 'heavy' medical equipment;

(2) encouraging the development of substitutes for care in hospital;

(3) introducing a limited list for pharmaceuticals which may be reimbursed under health insurance;

(4) promoting preventive action.

Controlling the number of hospital beds and 'heavy' medical equipment

Under a law passed in 1976, a hospital cannot be built or extended without the approval of the Minister of Health. A hospital plan is being prepared. The first step has been to compile complete information on all hospitals - their beds and occupancy, specialities, equipment and staff. There is no power to close a hospital because it is surplus to requirements.

Encouraging the development of substitutes for care in hospital

Old hospital buildings are being used to admit elderly patients who do not need the specialized facilities of a general hospital in order to reduce the length of stay in general hospitals or prevent admission to them.

Introducing a limited list for pharmaceuticals

Consideration is being given to the introduction of a list of medicines which can only be reimbursed under health insurance taking account of efficacy and cost. Such a list could be introduced under existing laws.

Promoting preventive action

A health card for children has been introduced on which will be recorded the results of all medical examinations up to the age of 21. Parallel to this, an extensive programme of health education has been launched with particular emphasis on cigarette smoking and excessive consumption of alcohol.

NETHERLANDS

Nearly 70% of the population (including voluntary contributors below the income limits) are covered by health insurance provided by about 71 Health Insurance Funds in 1976. The contributions paid by or for these compulsorily insured have to be submitted by the Sick Fund Council for approval by the Minister but this approval tends to be formal as the costs have to be incurred. The bulk of the remaining 30% of the population take out private insurance which is operated by profit and non-profit insurance agencies. In addition the whole population is compulsorily insured for serious risks (under a Law of 1968) which covers homes for the mentally retarded, and physically handicapped, nursing homes, and the cost of care in general and psychiatric hospitals after a stay of one year. The scheme is run by the Health Insurance Funds and the private insurers. General practitioners are paid on a capitation basis for the care of Health Insurance Fund patients and on a fee-for-service basis for other patients. Specialists are paid on a fee-for-service system, though a minority are paid salaries by the hospitals.

About 21% of hospitals are public hospitals and 27% are in private non-profit hospitals. (There are no profit making hospitals as such institutions would not be certified.) Hospitals are paid a rate per day. All rates are supervised by the Central Foundation on Hospital Tariffs. The Sick Fund Council normally applies the rates recommended by the Foundation for patients covered by the Health Insurance Funds but the Minister has the right to veto the decisions of the Sick Fund Council. The Foundation lays down the rates directly for private patients but again the Minister has a power of veto. The Sick Fund Council also approves the results of the negotiations between the Health Insurance Funds and the professions providing services (general practitioners, specialists, pharmacists, midwives, dentists and physiotherapists). The fees charged by general practitioners or specialists to the 30% of the population not covered by the Health Insurance Funds are supervised by the Ministry of Economic Affairs.

The methods which have been used by the Government for controlling the growth of costs are the following:

(1) restricting capital expenditure on hospitals;

(2) controlling the rates charged by hospitals;

(3) planning for a reduction in hospital beds;

(4) strengthening out of hospital care;

(5) recommending doctors to keep their prescribing within a prescribed list of products and to keep the dose of repeat prescriptions to stated quantities;

(6) limiting entry to medical school;

(7) promoting health education.

Control of hospital capital expenditure

Under a law of 1971, all capital expenditure to build or extend a hospital has to be authorized by the Minister under a building license system. The amount of new building work for which licenses were given 1975 was less than half that of 1974 in real terms and capital expenditure on hospitals has dropped substantially since 1972. The long-term plan is for a ratio of capital expenditure, about 40% lower than that of 1972. A monetary ceiling for hospital building was laid down by the Government for the year 1978.

The Control of hospital daily rates and establishments

The Minister has asked the Central Foundation on Hospital Tariffs to put as much restraint as possible on the rates charged by hospitals and the growth of daily rates has been heavily restricted in the last few years. A draft law aims to bring more coherence into rate setting for doctors and hospitals. This would extend the Minister's power to regulate the charges made by hospitals to the 30% of the population which is not compulsorily insured, to intervene in the negotiations conducted with the professions providing services to patients covered by the Health Insurance Funds and regulate payments made by doctors and dentists and others to private patients.

By a decree issued in 1976, the Government requires all general hospitals to obtain permission for any increase in staff or facilities which would lead to higher costs. A new draft decree was under decision when this report was prepared. Guidelines for the number of staff for different departments of hospitals have been established by the Government. Alternative systems of paying hospitals are being examined by the Department, the Health Insurance Fund Organizations and the hospitals. One possibility under discussion is the introduction of budget financing.

Hospital planning

Under an act of 1971 provinces are required to produce hospital plans which have to be approved by the Minister who after consultation has the responsibility for producing a national hospital plan. The Government plans to reduce the number of hospital beds per thousand population from 5.4 in 1978 to 5 by 1980 and possible later to 4. The reduction in the number of hospitals will be politically difficult in so far as the closure of hospitals meets with local opposition. At the time this report was prepared, a bill was before Parliament to amend the 1971 act which would give the Minister power to order the closure of a hospital. It would also require the hospital plans prepared by the provinces to be evaluated by the Central Foundation on Hospital Traffis and approved by the Central Government.

Strengthening out of hospital care

The reduction in the number of hospitals is to be facilitated by the strengthening of primary care, the encouragement of the establishements of more out-patient departments at hospitals and more nursing homes for long stay cases. A bill is before Parliament to extend the Ministers present powers to approve the building of in-patient facilities to cover other buildings for health care.

There are proposals to finance home care via the 'algemene wet bijzondere ziektekosten'. Previously home care was financed by voluntary contributions to the Cross Organizations and subsidies from Central Government and the provincial and municipal authorities.

In addition there are proposals for the sick funds to subsidize health centres where general practitioners work together with nurses, social workers, physiotherapists and other staff. At present such centres can only be subsidized by the Central Government on restricted conditions.

Prescribing and the price of pharmaceuticals

There is a list of drugs prepared by a Committee of experts and Health Insurance Fund officials within which doctors are requested but not required to limit their prescribing. The list now specifies the maximum dose which doctors are recommended to use for repeat prescriptions.

The introduction of price regulations for pharmaceutical products is under consideration.

Quota for Medical Schools

Since 1971 a system of quotas has been applied for admission to medical schools.

Prevention

Major efforts are being made to promote health education with particular emphasis on smoking, the excessive consumption of alcohol and unhealthy foods.

Proposals to increase the costs falling on patients

The Government has published proposals to require patients to pay directly the costs or primary care up to maximum of HFL 100 a year.

In addition single persons would pay HFL 10 per day for care in a general hospital.

UNITED KINGDOM

Health care is available to the whole population of the United Kingdom on a service rather than an insurance basis. The National Health Service is financed primarily out of taxation. Health Authorities have been established to administer the service at the local level separate from but parallel to local authorities. Health authorities are agents of the Secretaries of State responsible for the health service in England, Scotland, Wales and Northern Ireland. In the latter the same Authorities are also responsible for providing certain social services. In England there are 14 Regional Health Authorities with the responsibility of planning to which the 90 Area Health Authorities which operate the service are responsible.

Nearly all hospitals are publicly owned. Specialists operate from hospitals where they provide out-patients consultations as well as in-patient care. They are paid on a part-time or whole-time salaried basis. Central control is exercised over the medical establishments of hospitals. General Practitioners are paid by a mixture of capitation payment and allowances: fees are only paid for nights calls and certain preventive and obstetric work.

About 90% of the expenditure of health authorities is budget-limited. The remaining 10% of 'open-ended expenditure' covers general practitioners and the pharmaceuticals they prescribe, and the main dental and ophthalmic services.

The main measures taken by the Government to restrain the growth of expenditure on the health services and secure better value for the money spent are the following:

(1) reducing capital expenditure;

(2) reducing the rate of growth of current expenditure;

(3) rationalizing the hospital system;

(4) encouraging alternatives to care in hospital;

(5) establishing priorities through a planning system;

(6) increasing charges for dental and ophthalmic care;

(7) limiting cost increases in pharmaceutical services;

(8) encouraging prevention.

Reducing capital expenditure

Total capital expenditure on the Service is determined by the Government. Expenditure was reduced by about 20% in real terms between the financial years 1973/74 and 1976/77. In the last few years very few major hospital building schemes have been started. Cost limits have been laid down and regularly revised for over ten years on what can normally be spent to build a hospital to perform defined functions.

Reducing the rate of growth of current expenditure

The rate of annual growth of current expenditure has been cut from an average of almost 4% in the period 1970/71 to 1973 to an average planned growth between 1974/75 and 1977/78 of about 2%. Within the total management costs are being cut from about 5¾% of current expenditure in 1974/75 to 5¼% in 1979.

Rationalizing the hospital system

The planning of the whole hospital system has been in progress since 1948 and all major NHS hospital building schemes have for 30 years been subject to approval by the Ministers responsible for the health service.

The central control of establishments for specialists is an integral part of hospital planning. The number of hospital beds in England and Wales per 1 000 has been reduced from 10.2 in 1949 to 8.3 in 1976. The aim is to concentrate acute services (both in-patient and out-patient) on larger units. Between January 1974 and December 1976, 134 hospitals have been closed in England - most of them small. The vast majority of closures are agreed locally between health authorities and the representative bodies of consumers (Community Health Councils). Staff are offered posts in neighbouring hospitals.

Encouraging Alternatives to in-patient care in hospital

The whole thrust of policy is to encourage care in the community wherever this is appropriate to the needs of the individual concerned. There are in England about 22 000 (in whole-time equivalents) home nurses, midwives and health visitors (public health nurses) who work mainly in patients' own homes. Many of them work in very close association with 22 000 doctors in general practice as members of primary care teams. Expenditure on the home nursing services are planned to grow at the rate of about 6% per year despite the overall limits in the growth of expenditure. The number of home helps in about 42 000 in whole-time equivalents.

Encouragement is given to day hospitals, day surgery and diagnosis at out-patient departments to prevent unnecessary admission to hospital.

In the case of the mentally ill and mentally handicapped, more and more patients are being cared for in their own homes and in hostels in the community with support from day centres, day hospitals and the social and nursing services for care in the home.

Establishing priorities through the planning system

Health authorities are required to make short-term and longer-term plans within guidance given by Minister. The current service priorities for England are the mentally ill, mentally handicapped, the elderly, the disabled and children. Geographical distortions in the distribution of the money for running the service are being gradually reduced on the basis of objective criteria (the age and sex structure of the population and mortality rates with special allowances for the extra cost to services caused by the teaching of medical students).

Increasing charges for dental and ophthalmic services

The share of the cost of the main dental and ophthalmic services falling on patients has been raised from 20% in 1974/75 to 24% in 1977/78.

Limiting cost increases in pharmaceutical services

Both pharmacists margins and the profits made by pharmaceutical companies on supplies for the National Health Service have long been regulated. General practitioners whose prescribing appears to be excessive are visited by doctors employed by the Health Departments and sanctions can be applied. The proportion of expenditure on sales promotion allowed to the pharmaceutical industry when calculating profits is being reduced from 14% in 1975 to 10% in 1979.

Encouraging prevention

A new campaign to popularize prevention was launched in 1976 with the publication of Prevention and Health: Everybody's Business which has sold over 100 000 copies. Further publications are being produced on particular aspects of prevention. Particular emphasis is given to cigarette smoking and alcohol. Tighter restrictions on advertising have been agreed with the tobacco industry. Extra money has been allotted for the national health education campaign and to encourage the fluoridation of water. More and more local health education officers are being appointed. A free family planning service was introduced in 1974/75.

E. SUMMARY OF MEASURES TAKEN TO CONTROL EXPENDITURE

The different systems of organizing and financing health services in the countries of the Community have inevitably had a major influence on the type of measures which governments have been in a position to take to control the cost of health care. In countries where a major part of health service expenditure is subject to budget limits, the rate of real increase in those budgets can be directly controlled. In countries where the bulk of the renumeration of general practitioners comes from capitation or other payments which do not vary with the number of services provided (Denmark, the Netherlands, Italy and the United Kingdom), year to year changes in expenditure can be predicted with considerable reliability. Control is tighter if the number of doctors permitted to enter general practice in the public service or insurance scheme is centrally regulated. In both Denmark and Ireland a limit is placed on the number of doctors allowed to enter general practice at a cost to public funds. In insurance-based services where professions are paid per visit or on a fee-for-service basis and hospitals on a per bed-day basis, costs are harder to predict or control.

SHORT-TERM ACTION TO CONTAIN EXPENDITURE

(a) Budget limited services

The Irish Government froze the budgets of the Health Boards in 1976. In the United Kingdom the target rate of growth of the current expenditure of health authorities on hospital and community services was reduced to about 1½% a year in real terms for the period 1975/76 to 1979/80. A somewhat higher rate of growth was later permitted for the year 1978/79. The establishment of a national health service in Italy is designed to place budget limits on expenditure on health services.

(b) Insurance services where providers are paid fees and daily rates

The short run measures taken by governments in countries where doctors are paid on a fee-for-service basis or, in the case of hospitals, on a daily rate basis include the following:

(1) To limit the rate of growth of daily payments to hospitals (as in Belgium, Germany, France and the Netherlands).

(2) To secure that limits are agreed on the growth of total fees paid to doctors as in Germany.

(3) To negotiate changes in the relative incentives of the fee structure to discourage an excessive use of diagnostic and other services (Germany).

(4) In the case of prescribed pharmaceuticals:

(a) fixing the prices or limiting the profits of pharmaceutical companies in all countries in the Community except Germany and the Netherlands;

(b) limiting sales promotion activity by reducing what will be allowed as a cost when profits or prices are calculated (Belgium, France, Italy and the United Kingdom) or limiting the extent to which samples can be sent to doctors as in all countries in the Community except Ireland and Italy;

(c) regulating retail margins as in all countries in the Community except the Netherlands where margins are controlled by the pharmacists' profession;

(d) controlling the opening of pharmacies (e.g. Belgium, Denmark, France, Italy and Luxembourg);

(e) drawing up lists or formularies specifying those pharmaceuticals which either may be prescribed (e.g. Belgium, Denmark and Italy) or are recommended to be prescribed under health insurance (e.g. France, Germany and the Netherlands);

(f) specitying the quantities which may or should be prescribed in a particular prescription (e.g. Denmark, France, Ireland, Italy and the Netherlands);

(g) circulating information to doctors to encourage economical prescribing (e.g. comparative prices of similar products as in the United Kingdom and the Netherlands or Germany and Ireland where it is proposed that efficacy will also be taken into account).

(h) examining the prescriptions prescribed by doctors under health insurance as in all countries in the Community except Belgium.

(i) arranging for visits to be made to doctors whose prescribing appears to be excessive (Ireland and the United Kingdom).

(5) To reduce the scope of what is provided or reimbursable by health insurance or to increase the share of the cost falling on the patient. Action of this kind has been taken in the case of expenditure on pharmaceuticals in France and Germany, and in the case of hospital costs in Belgium and the dental and ophthalmic services in Denmark and the United Kingdom. It has also recently been proposed by the Government of the Netherlands in the case of primary care and general hospital care (for single persons only).

It should be noted that item 5 above relieves the burden on health insurance funds but increases the costs falling directly on patients or their insurers. The effect on the total cost of health services is less clear. In France, past changes in the extent of co-payment have not appeared to reduce the volume of services provided. On the other hand, raising or lowering prescription charges in the United Kingdom, have in the past led to considerable changes in volume.

In addition savings can be made in the short period by reducing the level of capital expenditure, most of which goes on hospitals. In countries where capital expenditure is financed out of taxation or grant aided by Government (as in Germany) or partly by Government and health insurance funds (as in France), this secures a saving in general government expenditure.

In the Netherlands the value of licenses for new building in 1975 was less than half the value of licenses granted in 1974 in real terms. In the United Kingdom capital expenditure has been reduced by about 20% in 1976/77 compared with 1973/74 and in Ireland it was cut from 1973 to 1976 but has been increased since. In France capital expenditure is, with some exceptions, being restricted to the replacement and upgrading of old buildings. In Italy, no new projects have been started since 1974 pending the full introduction of the national health services.

LONGER TERM ACTIONS TO CONTAIN COSTS

A great variety of longer-term actions which are intended wholly or partly to limit the growth of costs are being taken or are under discussion in the different countries of the Community. The main ones can be listed under the following headings.

(1) Changing the system of Financing:

(a) the Italian reform of the whole system of financing;

(b) experiments to change the system of paying hospitals;

(2) Changing the organization and deployment of services:

(a) developing greater continuity of responsibility by the same doctor for patients when cared for inside or outside hospital;

(b) extending or developing alternatives to in-patient care;

(c) encouraging prevention;

(d) establishing national priorities.

(3) Restricting the supply:

(a) hospital beds;

(b) of doctors.

(4) Extending or developing arrangements' for monitoring the supply of services (e.g. 'medical profiles')

1. Changes in the system of financing

(a) The Italian reform

Italy has changed the whole structure of financing health services from an insurance-based system with different health insurance funds each of which:

(i) paid hospitals for the care or its insured persons on a daily rate basis;

(ii) paid doctors for services to its insured persons either by fee-for-service or capitation;

To national health service financed mainly by health insurance contributions and secondarily by taxation under which:

(i) money is collected centrally and then channelled to regions and on to the local health units which provide the main hospitals and community health services;

(ii) General practitioners are paid on a capitation basis and specialists practising in public health centres are paid on a part-time or whole-time salaried basis.

(b) Payment of hospitals

The system of daily payments per patient to hospitals is widely regarded as unsatisfactory particularly because of the incentive for hospitals to retain patients longer than necessary.

Experiments in alternative systems of payment were undertaken in the FR of Germany, are being undertaken in France and the problem is under study in Belgium, Luxembourg and the Netherlands.

2. Changes in the organization and deployment of services

(a) Continuity of medical responsibility for patients inside and outside hospital

In Denmark, Ireland, the Netherlands and the United Kingdom nearly all specialist work both for in-patients and out-patients is provided at hospitals to which patients are referred by their general practitioners. In these countries patients (under the main insurance or service system) are required to register with a general practitioner to receive primary care: access to hospital-based specialists is normally by referral. In the other countries of the Community patients (under the health insurance system) have the right to go directly to any doctor, general practitioner or specialist.

An increasing proportion of doctors working in the community have tended to become specialists as distinct from general practitioners. Most or many of them work in premises which have no organizational connection with any hospital. When patients go directly to such a specialist he will often require diagnostic tests to be undertaken. If the patient needs to be admitted to hospital, a different doctor (often in the same specialty) takes over responsibility for the patient and may require the same or similar diagnostic tests before treatment is started. In such cases there cannot only be a duplication of diagnostic work but delay before treatment is started after admission to hospital, involving the cost of extra days in hospital. In Germany encouragement is being given to the development of out-patient activities by doctors working in hospitals and in-patient activities by doctors who only work outside hospitals. Similarly in Italy specialists on salaries to local health units will increasingly be expected to retain responsibility for a patient whom they have seen at a polyclinic, should the patient be admitted to hospital. The thrust of policy in France is also to establish further out-patient departments at public hospitals. The problem is less pressing in Belgium, France,and Luxembourg is a higher proportion of specialists have affiliations to hospitals into which they can admit their patients than is the case in Germany.

(b) Extending or developing alternatives to in-patient care in a general hospital

It is intended that the alternatives which are developed or extended will be cheaper than care in hospital. They may make it possible for patients to be discharged earlier from the general hospital as well as preventing admission to it.

One series of alternatives consists of different types of residential institution or hostel with a lower staffing ratio than a hospital and less elaborate equipment. They include community hospitals in Ireland and the United Kingdom, nursing homes in Denmark, the FR of Germany and France and the Netherlands, homes for the elderly in Belgium and France, and homes for physically and mentally handicapped children also in France. It has, however, been found in the Netherlands that the development of nursing homes has had the result of more patients being admitted from the community which tended to counteract the cost saving of shorter lengths of stay in expensively staffed and equipped general hospitals. A reduction of acute beds has been secured in the Netherlands by adapting some of the space previously used for beds for expanded facilities for out-patients. In France and the United Kingdom experiments have been made in concentrating certain short stay patients in 'five day wards' in general hospitals to avoid the expense of staffing over week-ends.

A further series of alternatives is to develop and extend different types of service for care in or from the patient's own home. Further emphasis is being placed on services in the patient's own home in Denmark and the United Kingdom. New initiatives to extend and develop such services are being taken in Belgium. Coupled with home care may the use of day centres or day hospitals such as are to be found in Denmark, Italy, the Netherlands and the United Kingdom and in Belgium and France for mental patients.

(c) Encouraging prevention

During the last five years a new emphasis has been given to preventive action throughout the Community. This has been partly a response to evidence that health status as indicated by mortality rates has not improved at a rate in any ways commensurate with increased real expenditure on health care. Thus it is hoped that a greater emphasis on prevention will lead to faster progress in this respect. It is also widely that carefully selected preventive programmes will not only be better but cheaper.

Certain types of preventive activity can bring early results and save health care costs. This clearly the case with the prevention of accidents, particularly road accidents (the use of seat belts, higher safety requirement for motor vehicles, lower speed limits or stronger enforcement of existing limits etc.). Some immunization and screening procedures may also be cost-effective in the shorter term though the scope for useful action in the latter field is more limited than was at one time thought.

Many other forms of preventive activity, even where successful, are slow in making an impact on health status - for example, campaigns against cigarette smoking and the abuse of alcohol and narcotic drugs. This may be because the programmes take time to influence behaviour or because it may be many years before

a change in behaviour influences the demand for health services. Moreover, while there may be savings in costly care in the medium term, it is less clear that the cost of health care will be lower in the very long term. Those who are saved from the risks of earlier disease and can thus be economically active for a longer period, may nevertheless survive to face the risks of costly care in old age. Thus certain types of preventive action, though of undoubted social advantage postpone and change the nature of health-care costs, they do not necessarily save them.

(d) Establishing national priorities

The possibilities of establishing national priorities for health care have attracted increasing interest over the past decade. Many countries have over the years added new priority services to their existing health services by, for example, requiring certain preventive services to be provided by health insurance funds (for example Germany and France), introducing new types of service such as family planning or making concerted efforts to improve performance in a specific area such as infant mortality. What is however new, is the interest in deliberately restraining the rate of growth of expenditure on some forms of health care so as to find room for much faster rates of growth of expenditure in other sectors of the health care budget. Restraint can be applied in health insurance systems by changing what health insurance will pay for or the extent to which it will do so (though the effect of such actions on the volume of what is supplied are not always what might be expected, as mentioned above.

Restraint can also be applied by directly limiting the number of doctors or hospital beds (see 3 below). In budget-financed health services, the capacity to change priorities in this sense is greater, swifter and more predictable. Service priorities have been developed and are being applied in the British National Health Service. A Committee which has been studying this question in Denmark has recently reported. There has also been considerable discussion of this issue in the Netherlands where the emphasis has been on nursing homes and improved staffing of hospitals for psychiatric patients. The assumption is that a lower rate of growth of health expenditure is more acceptable if there are widely agreed priorities on how it should be spent.

3. Restricting supply

(a) Of hospital beds

The proportion of hospital beds per 1 000 population can be restricted by control over new construction or by the closure of existing hospitals. The desire to restrict supply is based

on experience which suggests that hospital beds which are provided tend to be used and on the expectation that limited supply will lead to shorter lengths of stay so that beds can be released for other patients. Thus in some countries the control of supply runs parallel to initiatives to develop or extend alternatives to inpatient care (see 2 (a) above). Ten years ago, only France and the United Kingdom had a national hospital plan. Now every country in the Community has developed one. The ultimate power to approve plans rests with central government in all countries in the Community except Germany which this power is exercised by each 'Land'. So does the authorization of all major hospital building projects in all countries except the FR of Germany. Many countries in the Community are now planning for an overall reduction of general hospital beds per 1 000 partly in response to a downward revision of population projections.

In all countries in the Community, except Denmark and the United Kingdom a considerable proportion of the total number of beds are in private hospitals (Voluntary non-profit or profit making). Powers to order the closure of hospitals because they are surplus to requirements exist in the United Kingdom for NHS hospitals and a law before Parliament in the Netherlands when this report was written would give the Minister power to close any hospital. The County Councils in Denmark can in theory close surplus hospitals as can the 'Lander' in the FR of Germany and the authorities responsible for public hospitals in the other countries in the Community. But in practice the closure of hospitals is generally seen as presenting major political problems partly because of the local people's desire to have a local hospital and partly because of the effect on employment. Nevertheless, about 26 hospitals most of them small have been closed or transferred to other uses in Denmark in the period 1970 to 1977. Some older general hospitals have been converted to serve as nursing homes or institutions for long-term care and rehabilitation. In England, 134 hospitals have been closed over a period of three years with only a small minority of disputed cases.

(b) Of doctors

In some countries of the Community, action has recently taken to reduce the number of medical students. The full effect of such measures on the stock of doctors is very long-term. It is widely believed that an increase in the number of doctors per thousand population results in higher costs of health care, quite apart from the cost of the remuneration of the extra doctors, because of the costs they generate in their prescribing of medicines and their authorization of diagnostic tests, hospitals admissions and therapeutic procedures. In Ireland the total number of doctors able to enter the publicly financed health services is subject to control by the Government and in Denmark entry to general practice is restricted.

Medical schools in the United Kingdom have always operated quota systems for medical students. It has been the aim of the government to increase the intake of medical schools to reach a much higher level of output of doctors trained in Britain which will be obtained in the early 1980s. This will be the culmination of a long-term policy to expand medical education and make the United Kingdom less dependent on immigrant doctors. Similarly Luxembourg has a low ratio of doctors to population and there are no plans to limit the number of medical students. In Ireland, which has long been a net exporter of doctors, it is planned to reduce the number of students starting medical education. Two medical schools have agreed to cut medical student intake by 15% from 1979 and discussion was still in progress with the other two medical schools at the time this report was prepared. In the Netherlands quotas for entrants to medical schools were imposed from 1972 which reduced the number entering from 2 000 to 1 900. In 1977, there were 5 000 applicants for these 1 900 places. In Denmark a quota was established from 1976 when entry was reduced from about 1 000 in 1975 to 800 students of whom 600 are expected to complete the course. In both France and the FR of Germany a similar result is obtained by raising the standard of examinations in the early years of the course. Entry to medical school is unrestricted in Italy and Belgium and no action is contemplated to change this situation.

4. Extending or developing arrangements for monitoring the supply of services - 'Medical Profiles'

In the United Kingdom, the procedure of analysing the prescribing cost generated by each general practitioner and relating it to his 'list' of patients has long been established and visits by doctors employed by the Central Department have for many years made visits to general practitioners to discuss their prescribing costs. Where the visiting doctor is not satisfied with the explanation given by the general practitioner, the facts can be referred to the local medical committee which in turn can apply sanctions. In Ireland statistics are assembled which cover not only the cost of prescriptions but also the number of consultations and relate them to each general practitioner's list. Visits are paid by doctors employed by a central monitoring body representative of the Health Boards to general practitioners to discuss these statistics. Some sanctions exist to deal with abuses. In Denmark, sanctions have in the past been applied by the profession itself. In the Netherlands, an experiment in the use of medical profiles is being conducted in one province.

In Italy, statistics of all the activities of each doctor paid for each sick fund are regularly collected by the health insurance institute concerned. In the case of excessive prescribing or an excess of medical acts, sanctions are applied to doctors by the Provincial Medical Commission. This Commission is chaired by the Chairman of the Provincial organization of doctors and includes a representative of the Ministry of Labour and doctors appointed by the Ministry of Health, the Health

Insurance Institute, the employers, the trade unions and the provincial organization of doctors. This system of medical profiles is being continued under the new national health service.

In France, a system of statistics has been established which brings together the main activities of each doctor delivering health care to insured persons. These statistics of activity profiles are examined by a Committee established in each Department consisting on representatives of doctors and of health insurance funds. The procedure is only slowly developing and is mainly intended to make doctors aware of major variations in their activity from that of their colleagues.

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The present report, prepared by the experts mentioned above, does not engage the institutions of the European Community in any way.

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[1] The abbreviations after each title indicate the languages in which the documents have been published: DA = Danish, DE = German, EN = English, FR = French, IT = Italian, NL = Dutch.

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The organization, financing and cost of health care in the European Community

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